



May, 1957

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of the Michigan State Medical Society



EXERCISE . . .

*first step toward
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CLINICAL EXPERIENCE INDICATES FEWER RESISTANT STAPHYLOCOCCI CHLOROMYCETIN

As clinical reports on resistance of common pathogens to antimicrobial therapy gain increasing prominence,¹⁻⁵ need for broad-spectrum antibiotic therapy to which resistance is less likely to develop becomes even more apparent. Particularly troublesome are the staphylococci, which often fail to respond not only to commonly used antibiotic therapy but also to agents more recently introduced.⁶⁻¹⁰

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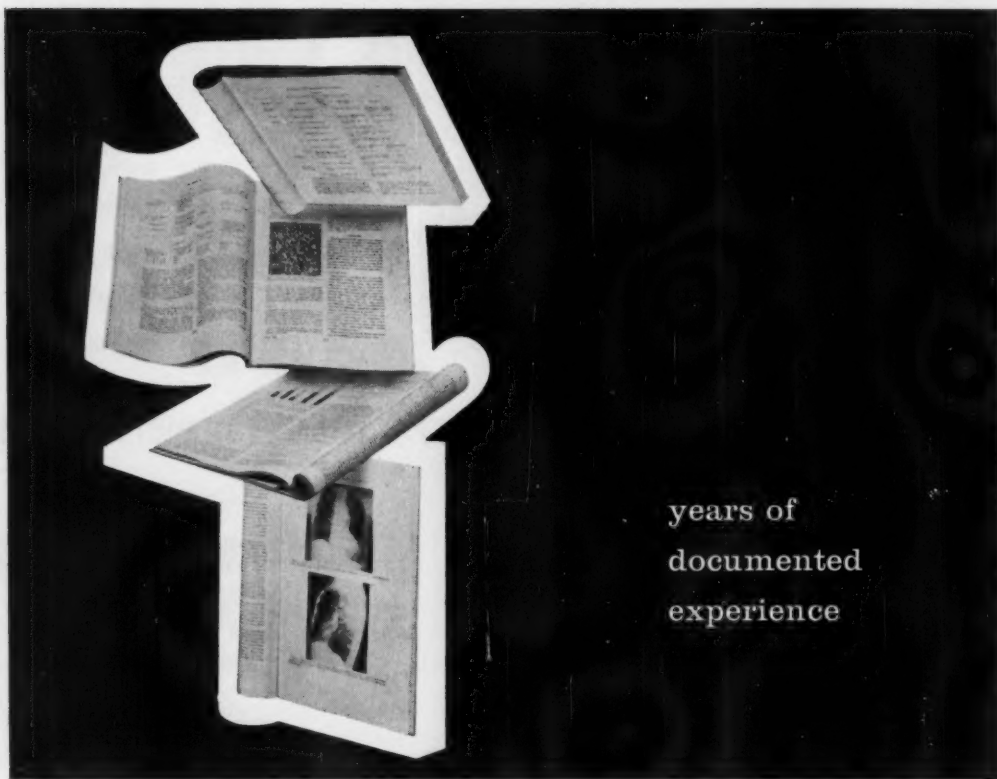
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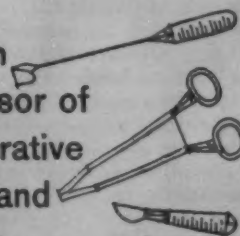
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MICHIGAN NOT ALONE

The "Blue Cross investigation bill" that had been adopted unanimously by the Indiana Senate, was adopted by the House this month without a dissenting vote.

The bill established a special, non-partisan, joint house-senate committee to "conduct a study of the operations of all companies or associations or others engaged in the business of providing hospitalization or prepaid hospital expense plans."

The resolution itself does not specifically mention Blue Cross, but it was introduced by Senator Townsend, who had been previously quoted following an announcement of Blue Cross rate increases as saying that "perhaps the whole situation needs investigating." As a result the bill has been tagged in the press as a "Blue Cross Probe."

The resolution calls for the special committee to file a report with the legislative advisory commission on or before September 15, 1958, for transmission to the next session of the assembly, which will open January, 1959.—National Underwriter, March 14, 1957.

DOCTOR AMENDMENT TO DRAFT ACT

The Defense Department preparing for expiration of the special doctor draft act next June 30, is moving ahead with legislation to amend the regular draft act so that physicians may be called up selectively. The bill is now before the Budget Bureau, which is expected to clear it soon for presentation to Capitol Hill.

The proposed amendment, in effect, would waive the Selective Service Act's prohibition against discrimination to the extent that physicians, dentists and allied scientists could be called up by their professional classification. Thus these men, because they are in the particular professional groups, would be subject to special calls and not necessarily inducted in the same order as others in their same age group.

One phase of the situation that is causing some concern in the medical profession is the possibility that June 30 will see the end not only of the special doctor draft act, but also the expiration of the National Advisory Committee to Selective Service (the Rusk committee) and its affiliated volunteer state and local committees. The Defense Department Amendment setting up the new doctor procurement mechanism under the regular draft has no provision for continuing the committee. Selective Service had not recommended retaining the committee.

The national, state and local committees, made

up of physicians and dentists, have been the liaison between the military services and Selective Service on the one hand and the medical professions and medical schools on the other.—AMA Washington Letter.

CHANGES IN "INTERMEDIARY" HOME-TOWN SYSTEM

It is neither the desire nor the intention of Veterans Administration to eliminate the "intermediary" system for administering the home-town care program, an arrangement in which a third party (a state medical agency) receives billings and makes payments. This was the gist of a statement by VA's chief medical director, Dr. William S. Middleton, at a Washington meeting attended by representatives of eight states and Hawaii, where the "intermediary" system remains in effect. Also present were representatives of the AMA's Washington Office and the national Blue Shield. Dr. Middleton said he felt sure that by mutual consideration of the problems involved agreement could be reached that would be acceptable to all. It was decided that contracts would be continued, based on the following major points:

1. Contracts uniform for the eight states and Hawaii, and generally modeled on the Michigan state plan.

2. Authorization for extended care treatment to be made by VA, with a copy of the authorization going to the contractor.

3. Contractors to continue their audits and receive invoices (doctors' monthly bills) with medical reports.

4. Physicians' summary reports, generally quarterly, to go directly to VA.—AMA Washington Letter, March 29, 1957.

(The eight states are California, Colorado, Michigan, North Carolina, Oregon, South Dakota, Washington, and Wisconsin.)

ANNUAL MEDICAL GOLF TOURNAMENT

The American Medical Golfing Association will hold its forty-first tournament June 3, 1957 at the well-known Westchester Country Club, Rye, New York. It is a championship layout, with beautifully cared for greens and fairways. This famous resort provides two eighteen-hole courses, a Beach Club on Long Island Sound, tennis courts and even a polo field.

As in the past few years, eighteen-hole competition will determine championships and will be the basis for the awarding of prizes. The New

(Continued on Page 554)

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since it is less likely to produce excessive fatigue and weakness than does reserpine."¹ Up to 80% of patients with mild labile hypertension and many with more severe forms are controlled with Rauwiloid alone.

1. Moyer, J.H.: J. Louisiana M. Soc.
108:231 (July) 1956.

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"...relief from anxiety resulted in generally increased intellectual and psychomotor efficiency with a few exceptions."² Rauwiloid is outstanding for its *nonsoporific* sedative action in a long list of unrelated diseases not necessarily associated with hypertension but burdened by psychic overlay.

2. Wright, W.T., Jr., et al.: J. Kansas M. Soc.
57:410 (July) 1956.

Dosage: Merely two 2 mg. tablets at bedtime.
After full effect one tablet suffices.

Best first step when more potent drugs are needed

Rauwiloid is recognized as basal medication in all grades and types of hypertension. In combination with more potent agents it proves synergistic or potentiating, making smaller dosage effective and freer from side actions.

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In moderate to severe hypertension this single-tablet combination permits long-term therapy with dependably stable response. Each tablet contains 1 mg. Rauwiloid (alseroxylon) and 3 mg. Veriloid (alkavervir). Initial dose, 1 tablet t.i.d., p.c.

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In severe, otherwise intractable hypertension this single-tablet combination provides smoother, less erratic response to hexamethonium. Each tablet contains 1 mg. Rauwiloid and 250 mg. hexamethonium chloride dihydrate. Initial dose, $\frac{1}{2}$ tablet q.i.d.

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First report on one of the
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since the introduction
of rauwolfia:
.....
a tranquilizing-
.....
antihypertensive agent
.....
which combines the potency
.....
of the rauwolfias with
.....
significantly fewer and
.....
milder side effects.
.....

In mid-1955, Abbott Laboratories released for clinical trial a new alkaloid of *Rauwolfia canescens*. This new alkaloid, later named Harmony, received special attention because of the high potency and low toxicity it exhibited in extensive pharmacological testing.

Since that time, Harmony has been tried in conditions ranging from mild anxiety to major mental illnesses and in hypertension. Every characteristic of the drug was studied... evaluated... compared. And from the reports, one fact stands out:

- In more than two years of clinical evaluation, Harmony has exhibited significantly fewer and milder side effects in comparative studies with reserpine. This, while demonstrating effectiveness comparable to the most potent forms of rauwolfia.
- Most significant: Harmony causes less mental and physical depression. *And there are very few reports of the lethargy seen with many other rauwolfia preparations.*

This is not to suggest, of course, that side effects will not occur with Harmony—as with any potent therapeutic agent. But the mildness of side effects, in the few instances in which they have been reported, suggests Harmony as a drug of choice in conditions ranging from mild anxiety to major mental illness and in essential hypertension.

Why fewer and less severe side effects?

Some investigators suggest that the evidence of less parasympathetic effect with Harmony in animals might also be true in man. In chronic toxicity studies with Harmony this was manifested by less diarrhea, “bloody tears” and ptosis in rats than was observed with the same dosage of reserpine. Dogs also exhibited milder side effects—in particular, diarrhea. No organ toxicity or hematological change was observed with Harmony over a wide dosage range.

Harmony as a tranquilizer

While Harmony's safety is most impressive, clinical investigators reported other notable characteristics for this wide-range

Harmonyl*

(Deserpidine, Abbott)

tranquilizer. For instance, following an eight-month study of chronic, hospitalized mental patients, Ferguson¹ reported:

- Harmonyl benefited at least 15% more overactive patients than oral reserpine.
- Harmonyl was more potent in controlling aggression, requiring only one-half to two-thirds the dosage of reserpine.
- A number of patients experiencing side reactions on reserpine were completely relieved when changed to Harmonyl.

In his summary Ferguson concluded: "*The most notable impressions were the absence of side effects and relatively rapid onset of action with Harmonyl.*"

Harmonyl in hypertension

Hypertension studies show that the average reduction in blood pressure obtained with Harmonyl compares closely to that obtained with reserpine. The tranquilizing effect of the two drugs also appeared similar, except that few cases of giddiness, vertigo, sense of detached existence or disturbed sleep were observed with patients receiving Harmonyl.

Dosages In mild anxiety, as little as 0.1 mg. of Harmonyl a day may be effective. In institutionalized psychiatric patients, not less than 2 to 3 mg. a day is likely to be beneficial.

In mild essential hypertension, treatment may be started with one 0.25-mg. tablet three or four times a day. After about ten days (or sooner, depending upon response), dosage may be reduced. A maintenance dose of 0.25 mg. daily is often sufficient.

Precautions. As with other forms of rauwolfia, Harmonyl must be used cautiously in peptic ulcer and epilepsy and in patients about to undergo surgery or electroshock treatment. Despite infrequent reports involving depression, patients with a history of depressive episodes should be watched carefully.

Professional literature is available upon request.

Supplied: Harmonyl is supplied in 0.1-mg., 0.25-mg. and 1-mg. tablets.

Abbott

Reference: 1; Ferguson, J. T.: Comparison of Reserpine and Harmonyl in Psychiatric Patients: A Preliminary Report, *Journal Lancet*, 76:389, December, 1956.

*Trademark



ANNUAL MEDICAL GOLF TOURNAMENT

(Continued from Page 550)

York Committee, headed by James T. Daniels, M.D. has made excellent arrangements for a full day of good golf and relaxation for all golfing medics.

The Westchester Country Club located some thirty miles from Grand Central Station, can be easily reached by train or bus to Rye, or, if several golfers join together, by Carey Car Service or Rent-a-Car Service. Golfers wishing to have quarters closer to the Club can secure reservations at nearby hotels in Rye or Harrison, New York, or in Greenwich, Connecticut.

Tournament play will start at 8:30 a.m. Players may tee off up to 2:00 p.m. Buffet luncheon, banquet, prizes and green fees are included in the cost of the day's activities. The banquet will be served promptly at 7:00 p.m. followed by awarding of prizes. All male members of the American Medical Association are eligible to participate in the tournament. Notice of further details and advance registration card may be secured by writing Bob Elwell, 3101 Collingwood Blvd., Toledo 10, Ohio.

Players should present verification of their home club handicap, signed by their club secretary, otherwise handicap is set by the AMGA Handicap Committee.

The following New York doctors will assist Dr. Daniels, Walter Heldmann, Robert Warren, Leonard Goldman, Samuel Thompson and Frank La Gattula.

The AMGA is under the direction of the following officers: Joseph Corr, President, New York; Paul Wyne, First Vice President, San Francisco; John Growden, Second Vice President, Kansas City, Mo.; and D. H. Houston, Seattle, Permanent Chairman of the Advisory Committee.

SEVENTH AMERICAN CONGRESS ON MATERNAL CARE

A comprehensive review of Complete Maternity Care will be presented by The American Committee on Maternal Welfare at the Seventh American Congress on Maternal Care (formerly known as the *American Congress on Obstetrics and Gynecology*) to be held at the Palmer House, Chicago, July 8-12, 1957.

The five-day Congress—under the leadership of F. Bayard Carter, M.D., Professor and Head of the Department of Obstetrics and Gynecology at Duke University, Durham, North Carolina, and Samuel B. Kirkwood, M.D., Commissioner of Public Health for the Commonwealth of Massachusetts and Professor of Maternal Health at Harvard Medical School—will present topics dealing

with the interprofessional approach to maternal and infant care. The Program Committee, composed of organizational representatives from obstetrics-gynecology, general practice, pediatrics, anesthesiology, nurse anesthesia, nursing, nutrition, public health, hospital administration, mental hygiene and social service, has developed a program to afford maximum opportunity for audience participation.

Speakers and registrants at the panel discussions, luncheons, round tables, breakfast conferences and Laymen's Forum will examine and pursue the questions: "WHAT is Complete Maternity Care?" "WHO Provides It?" "HOW is Complete Maternity Care Provided?"

Four thousand are expected to attend.

Further information can be attained by writing The American Committee on Maternal Welfare, 116 South Michigan Avenue, Chicago 3, Illinois.

NURSING SCHOLARSHIPS

The College of Nursing at Wayne State University recently announced that six scholarships for student nurses are again available for the 1957-1958 academic year.

Five Helen Newberry Joy scholarships are available to students in the metropolitan Detroit area, and an alumni grant is available to students throughout Michigan.

These scholarships offer \$850 to cover the major part of tuition costs for the eight semesters and one summer session of the basic professional program. The grants are offered on a competitive basis to selected students who wish to enter the College of Nursing in September, 1957.

Applicants face no age, sex, race or creed restriction when applying for the scholarships. For information, write Dean Katharine Faville, College of Nursing, Wayne State University.

HIGHLIGHTS OF EXECUTIVE COMMITTEE OF THE COUNCIL
Meeting of March 12, 1957

- **Medicare Program.** Jay C. Ketchum reported that to date some 1,100 claims have been received; also that re-negotiation is necessary so that x-ray billings will be paid by Michigan Medical Service rather than by Michigan Hospital Service as at present. A letter from the Michigan Society of Anesthesiologists re Medicare was read and referred to Secretary Foster for reply.
- **Michigan Medical Service.** Executive Vice President Ketchum reported that the marked increase in utilization would force an increase in rates, soon. The Executive Committee notified Michigan Medical Service that so far it has no recommendations to Michigan Blue

(Continued on Page 556)

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smooth
muscle
spasm
gets
rough
on your
patients



Like oil on troubled waters...



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provides superior spasmolysis



through provision of natural belladonna
alkaloids in optimal ratio, with phenobarbital

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DONNATAL ELIXIR (per 5 cc.)

Hyoscyamine Sulfate.....0.1037 mg.
Atropine Sulfate0.0194 mg.
Hyoscyine Hydrobromide..0.0065 mg.
Phenobarbital (¼ gr.).... 16.2 mg.

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HIGHLIGHTS OF THE COUNCIL

(Continued from Page 554)

- Shield concerning the adoption of the revised \$5,000 Fee Schedule.
- **1957 Michigan Clinical Institute.** The record-breaking total of 3,247 persons registered at the March 13-14-15 MCI included 1,654 doctors of medicine. A report on the promotion of this meeting, developed and executed by the MSMS Executive Office, was reviewed.
 - **1957 MSMS Annual Session, September 25-26-27 in Grand Rapids.** C. Allen Payne, M.D. of Grand Rapids was appointed as General Chairman for this Session. A page in the Annual Session Program, seeking the registrants' attitudes on the convention, was authorized.
 - **The name of A. Hazen Price, M.D.,** of Detroit, was nominated to the Governor for the State Hospital Advisory Council. The names of William Bromme, M.D., Detroit, William M. LeFevre, M.D., Muskegon, and D. R. Smith, M.D., of Iron Mountain, were nominated, as MSMS representatives, to the Board of Trustees of Michigan Hospital Service.
 - **Ethics.** The appeal of a member of the Wayne County Medical Society, from an order of discipline, was referred to the MSMS Ethics Committee.
 - **Councilor Conferences,** which proved so successful in 1956, were authorized throughout Michigan for the summer of 1957.
 - **Advisory Committee of Michigan Hospital Service.** The following names were nominated to Blue Cross for its proposed Advisory Committee: C. W. Colwell, M.D., Flint; L. Fernald Foster, M.D., Bay City; W. S. Jones, M.D., Menominee; W. M. LeFevre, M.D., Muskegon; J. D. Miller, M.D., Grand Rapids, and Ralph W. Shook, M.D., of Kalamazoo.
 - **Documentary Film of New Wayne County Medical Society Building.** The Council Chairman appointed the following committee to develop this film: W. B. Harm, M.D., Chairman; L. J. Bailey, M.D., L. R. Leader, M.D.; A. E. Schiller, M.D., and W. W. Babcock, M.D., Ex Officio.
 - **Legal Counsel Lester P. Dodd** presented opinions on (a) use of the word "clinic"; (b) a hospital problem in Oakland County.
 - **House of Delegates Speaker Kenneth H. Johnson, M.D.,** Lansing, announced that he had called a special session of the MSMS House of Delegates in Detroit for Saturday, April 27, 1957, by request of The Council.
 - **Committee Reports.** The following were reviewed: (a) Home Town Medical Care Program, meetings of January 26 and February 10; (b) Tuberculosis Control Committee, January 11; (c) Site Committee (special report of Chairman K. H. Johnson, M.D.); (d) Public Relations Committee, January 26; (e) Joint Committee to Meet with Michigan Society of Neurology and Psychiatry and Michigan Psychological Association, January 30; (f) National Defense Committee, January 30; (g) Venereal Disease Control Committee, January 31; (h) Michigan Cancer Co-ordinating Committee, January 31; (i) Rheumatic Fever Control Committee, February 6; (j) Comprehensive Prepaid Insurance Plans Committee, February 6-27 and March 6 and also joint meeting of February 6 with Committee on Michigan Medical Service and separate meeting of the latter committee on March 3; (k) Geriatrics Committee, meeting of February 7; (l) Advisory Committee to WCMS Documentary Film, February 7; (m) Rural Medical Service Committee, February 21; (n) Arbitration Committee, February 22; (o) Mental Health Committee, February 28; (p) Healing Arts Study Committee, February 10; (q) Liaison Committee with Michigan State Board of Registration in Medicine, February 21.
 - **Proposed Fire Regulations for Hospitals**—report of L. A. Drolett, M.D., Lansing, was presented and received with thanks to Dr. Drolett for an excellent report.
 - **American Medical Education Foundation.** Plan of promotion by Michigan Chairman C. E. Umphrey, M.D., Detroit, was considered, and a vote of thanks to Dr. Umphrey was placed on the minutes.

MEDICAL MEETINGS AND CLINIC DAYS

A list of known medical meetings and clinic days, sponsored by county medical societies and other physician groups in Michigan, follows:

1957

June 21-22	Upper Peninsula Medical Society	Calumet
July 11-13	Mid-Summer Session of The Council, MSMS	Mackinac Island
July 25-26	Coller-Penberthy Medical Conference	Traverse City
Sept. 25-27	MSMS Annual Session	Grand Rapids

relaxes both mind and muscle

***for anxiety
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everyday practice***

- well suited for prolonged therapy
- well tolerated, relatively nontoxic
- no blood dyscrasias, liver toxicity, Parkinson-like syndrome or nasal stuffiness
- chemically unrelated to phenothiazine compounds and rauwolfia derivatives
- orally effective within 30 minutes for a period of 6 hours

For treatment of **anxiety and tension states and muscle spasm**

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THE ORIGINAL MEPROBAMATE

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Tranquilizer with muscle-relaxant action

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SUPPLIED: (Bottles 50 tablets)
400 mg. scored tablets
200 mg. sugar-coated tablets

USUAL DOSAGE: One or two 400 mg. tablets t.i.d.

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CONVENIENT
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NEW
200 mg.
SUGAR-COATED
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STANDARD
400 mg.
SCORED
TABLETS

CM-3421-66

reports
of
clinical
studies

1 "I have used meprobamate in my general psychiatric practice since April, 1955, and believe it to be [a] drug of choice for relief of tension, anxiety and insomnia."

Lemere, F.: Northwest Med. 54: 1098, 1955.

2 "... the patient [taking Miltown] never describes himself as feeling detached or 'insulated' by the drug. He remains... in control of his faculties, both mental and physical, and his responsiveness to other persons is characteristically improved."

Sokoloff, O. J.: A.M.A. Arch. Dermat. 74: 393, 1956.

3 "Of special importance is the fact that Miltown does not appear to affect autonomic balance—which in alcoholics is often unstable..."

Thimann, J. and Gauthier, J.W.: Quart. J. Stud. Alcohol. 17: 19, 1956.

4 "The [relative] absence of toxicity, both subjectively and objectively, is an important feature in favor of Miltown. In addition, there were no withdrawal phenomena noted on cessation of therapy, whether it was withdrawn rapidly or slowly."

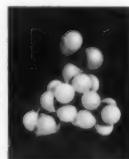
Borru, J.C.: J.A.M.A. 157: 1596, 1955.

5 "Miltown is of most value in the so-called anxiety neurosis syndrome, especially when the primary symptom is tension... Miltown is an effective dormifacient and appears to have... advantages over the conventional sedatives except in psychotic patients. It relaxes the patient for natural sleep rather than forcing sleep."

Selling, L.S.: J.A.M.A. 157: 1594, 1955.

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A REPORT...

to the Doctors and Hospitals of Michigan

YOUR BLUE CROSS-BLUE SHIELD PLAN PROVIDED MORE BENEFITS FOR MORE PEOPLE . . IN 1956

Here are the facts, as of December 31, 1956

- Michigan Blue Cross paid for 537,719 hospital admissions, an increase of 7.5% for the year.
- Michigan Blue Shield paid for 2,212,791 medical and surgical services, an increase of 31.4%.
- Michigan Blue Cross enrollment stood at 3,621,746, Michigan Blue Shield enrollment at 3,613,263. Thus, 99.77% of Blue Cross mem-

bers have Blue Shield, highest percentage of any Plans in the world.

- Nearly 18,000 Michigan business, labor, professional and farm groups now offer Blue Cross-Blue Shield coverage to their members.

- Payments to doctors and hospitals amounted to \$138-million last year alone. During their 18 years of operation, your Michigan Plans have made payments totaling more than \$735-million for care of members.

STATEMENT OF CONDITION

Report of Condition as of the Close of Business December 31, 1956

MICHIGAN HOSPITAL SERVICE

ASSETS

Cash in Banks and Office.....	\$ 5,197,067.47
Real Estate—Home Office Property.....	1,717,177.65
United States Government Securities.....	26,699,660.08
Accrued Interest.....	140,858.83
Subscription Fees—Receivable.....	223,567.50
Funds Advanced for Veterans Administration.....	— 0 —
Other Assets.....	622,664.50
Total Assets.....	\$34,600,996.03

LIABILITIES AND RESERVES

Reserve for Payment for Services Rendered Subscribers (Including Unreported).....	\$18,302,100.26
Reserve for Unearned Subscription Fees.....	6,705,930.51
Reserve for Contingencies.....	8,838,387.85
Other Liabilities.....	754,577.41
Total Liabilities and Reserves.....	\$34,600,996.03
Total Benefits Paid Since Inception.....	\$522,635,050.88

MICHIGAN MEDICAL SERVICE

ASSETS

Cash in Banks and Office.....	\$ 1,491,805.19
Real Estate, Home Office Property.....	1,563,915.54
Bonds.....	11,530,615.18
Preferred Stocks, at Market.....	86,575.00
Interest Due and Accrued.....	58,984.79
Subscription Fees—Receivable.....	117,828.88
Funds Advanced for Veterans Administration.....	94,692.89
Other Assets.....	433,891.61
Total Assets.....	\$15,378,309.06

LIABILITIES AND RESERVES

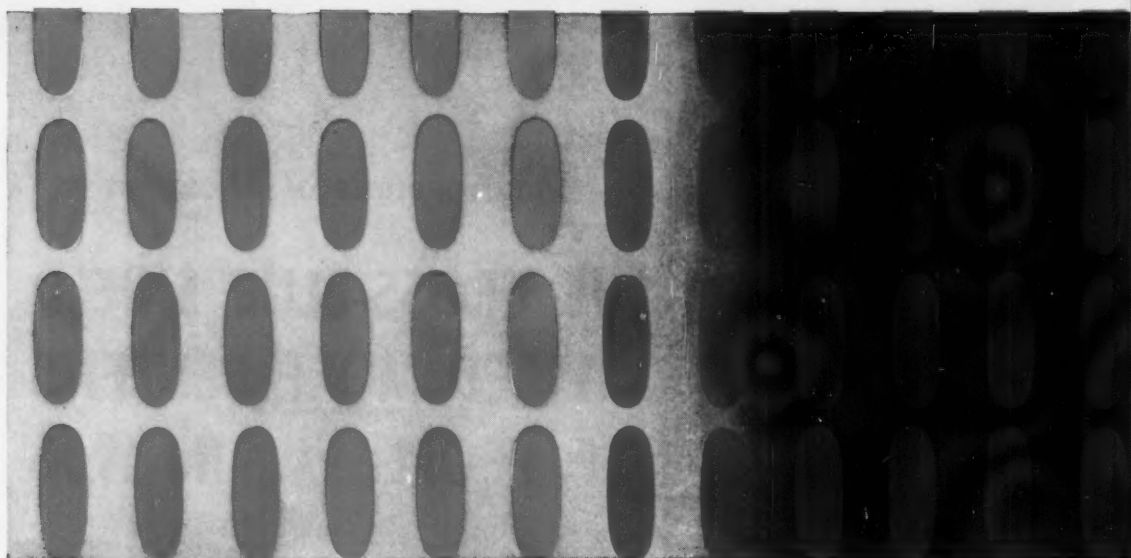
Reserve for Payments for Services Rendered Subscribers (Including Unreported).....	\$ 6,947,039.58
Reserve for Unearned Subscription Fees.....	2,567,072.60
Reserve for Contingencies.....	5,812,312.60
Other Liabilities.....	51,884.30
Total Liabilities and Reserves.....	\$15,378,309.08
Total Benefits Paid Since Inception.....	\$213,100,955.49



BLUE CROSS-BLUE SHIELD

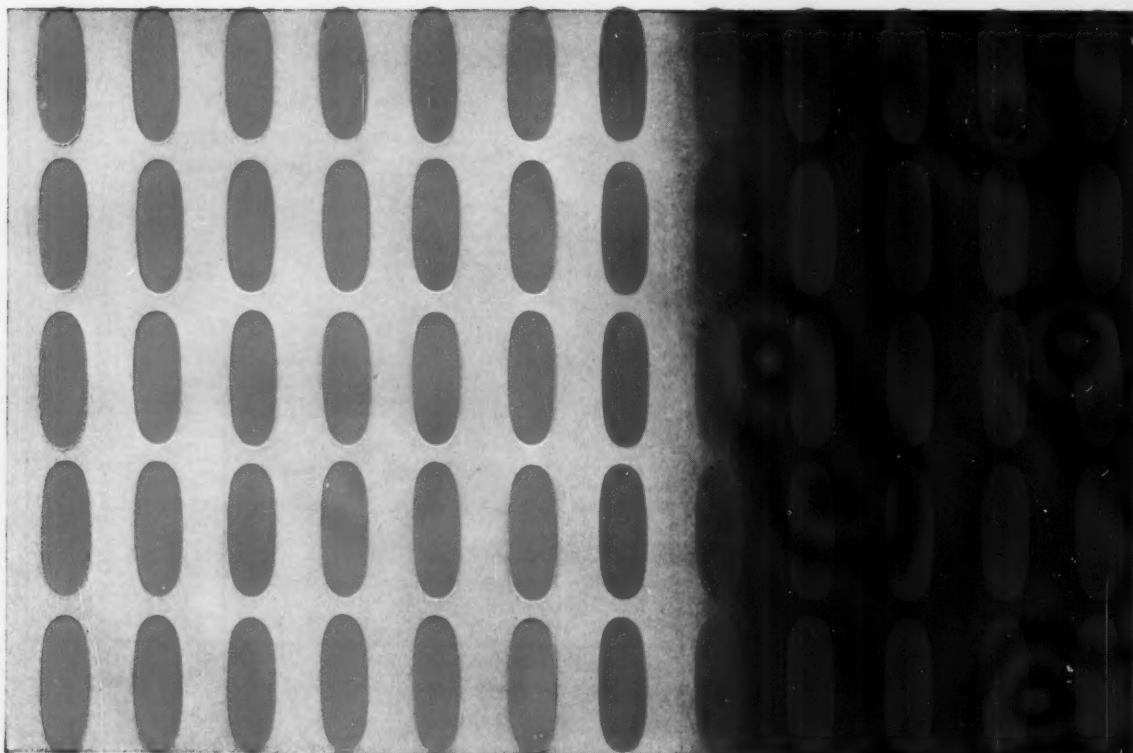
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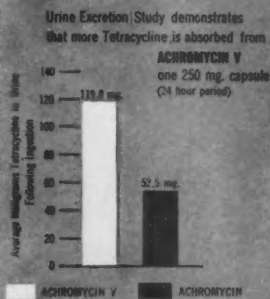
"the only one of its kind"

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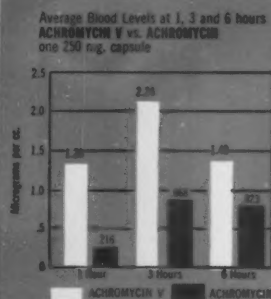
CLINICALLY BUFFERED WITH SODIUM METAPHOSPHATE

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for greater clinical
efficiency

GREATER ANTIBIOTIC ABSORPTION



FASTER BROAD-SPECTRUM ACTION



ACHROMYCIN V admixes sodium metaphosphate with tetracycline. ACHROMYCIN v provides greater antibiotic absorption/faster broad-spectrum action and is indicated for the prompt control of infections, seen in everyday practice, hitherto treated with other broad-spectrum antibiotics. Available: Bottles of 16 and 100 Capsules.

Each Capsule (pink) contains:

Tetracycline equivalent to tetracycline HCl.. 250 mg.

Sodium metaphosphate 380 mg.

ACHROMYCIN V dosage: 6-7 mg. per lb. of body weight per day for children and adults.

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What the Future Holds for General Practice

At the Symposium on Trauma in Lansing, Michigan, March 6, 1957, Austin Smith, M.D., Editor and Managing Publisher of *The Journal of the American Medical Association*, delivered a significant address at the noon luncheon. Approximately 400 members of the Michigan Academy of General Practice and their wives attended.

ical socialization, but stressed that organizations could do only so much.

"The footwork must be done by the individual members," he said. "In Sweden, the family doctor has ceased to exist. In Norway, physicians are limited in their use of drugs. In Japan, medical affairs are divided among various departments of the government with the result that the doctors are forced to follow a multitude of



(Left to right) Arch Walls, M.D., President MSMS and Moderator of Symposium; Austin Smith, M.D., Editor JAMA and Luncheon Speaker, "What the Future Holds for General Practice"; F. P. Rhoades, M.D., President-Elect MAGP and Chairman of Symposium on Trauma.

Dr. Smith stressed the fact that the future of the general practice of medicine rests primarily in the hands of the generalists. In other words, the future will be what the general practitioners of medicine work to make it. He pointed out that since the majority of practicing physicians of the country are general practitioners, it follows that the future of the general practice of medicine will be the future of the practice of medicine in general. He made a strong plea for all doctors and all segments of medicine to resolve their differences and join hands in a united front to prevent the catastrophe that has overwhelmed the profession in many other countries. As examples, he cited the current spectacle of the doctors of England having to threaten a strike in order to secure sufficient recompense to keep pace with the increased cost of living.

Dr. Smith's address is significant because, due to his position in organized medicine, it cannot but reflect the official thinking and attitude of the hierarchy of the AMA. He spoke of the work of the World Medical Association in combating med-

policies. In Chili, all doctors are state employees." Doctor Smith charged "the International Labor Organization and the International Social Security Organization, with offices in Geneva, Switzerland, are actively engaged in a concerted effort to bring about government control of medicine in all nations. If their program is adopted, all physicians would become mere technicians subject to the absolute control of government bureaucrats." He pointed out that "the W.M.A., of which the A.M.A. is a member, stands for (1) Freedom of choice of physician; (2) Freedom of choice of hospital; and (3) No restriction on type of medication used or mode of treatment by the physician."

Dr. Smith concluded by saying,

"As long as the family doctor continues to play a dominant role in the medical picture, he will, in a large measure, insure the survival of medical freedom."

Dr. Smith was introduced at the noon luncheon by Dr. F. P. Rhoades, Chairman of the Symposium. Dr. John W. Rice, President of the Michigan Academy of General Practice, moderated the morning session, and Dr. Arch Walls, President of the Michigan State Medical Society,

(Continued on Page 564)

perhaps the safest ataraxic known . . .

PEACE OF MIND

ATARAX[®]

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Tablets-Syrup

safety highlighted in every clinical report.

Depending on the condition treated, the effectiveness of ATARAX has ranged from 80 to 94%. But clinicians have agreed unanimously on its safety. After more than 85,000,000 doses — many on long-term administration at high dosage — no evidence of addiction, blood dyscrasias, parkinsonian effect, liver damage, depression or other serious side effects have been reported.

calms tense patients.

ATARAX produces its calming, peace-of-mind effect without disturbing mental alertness. In the tension/anxiety conditions for which it is intended, you will find ATARAX effective in about 9 of every 10 patients.

prescribe ATARAX as follows:

Adults: usually one 25 mg. tablet, or two tsp. Syrup, three times daily.

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Supplied: Tablets, tiny 10 mg. (orange) and 25 mg. (green), bottles of 100. Syrup, 10 mg. per tsp., pint bottles.

Since response varies from patient to patient, dosage should be adjusted accordingly. Prescription only.



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Heart Beats

HEART ASSOCIATION ELECTS OFFICERS

M. S. Chambers, M.D., a Flint internist, was elected President of the Michigan Heart Association on March 15, 1957, at the Association's annual board meeting which was held in Detroit at the time of the Michigan Clinical Institute. Dr. Chambers was one of the original incorpora-

tion. The Dodrill-GMR Mechanical Heart, which was designated one of the top ten scientific developments in 1952 by the National Association of Science Writers, was the first device of its kind in medical history to be used successfully on human patients undergoing heart surgery. Dr. Dod-



HEART ASSOCIATION HONORS CHARLES E. WILSON AND CHARLES F. BARTH

(Left to right) M. S. Chambers, M.D., Flint, looks on as Secretary of Defense Charles E. Wilson and Mr. Charles F. Barth, Jr., accept special honorary life membership plaques in the Association from E. A. Irvin, M.D., Dearborn. The presentations were made at the Association's annual dinner meeting held in Detroit, on March 14, 1957, in conjunction with the Michigan Clinical Institute. Mr. Wilson was honored for his efforts in organizing the Michigan Heart Association in 1948-1949 when he was head of General Motors. He served as Association Board Chairman for seven years. Mr. Barth, now ninety and a retired Chevrolet vice president, did not appear personally, but his son, Charles F., Jr., accepted his plaque. Mr. Barth has supported several heart research projects.

tors of the Association in 1949 and he has served on the Board of Trustees and numerous committees since that time. He is also serving a three-year term as a member of the Board of Directors of the American Heart Association.

F. D. Dodrill, M.D., a Detroit surgeon, who headed a medical and engineering research team which developed the first successful mechanical heart, was elected President-Elect of the Associa-

rill, also, was among the original incorporators of the Michigan Heart Association.

Mr. George A. Jacoby, GM Director of Personnel Relations and a former Flint resident, was re-elected for a second term as chairman of the Board of Trustees.

The retiring MHA President, E. A. Irvin, M.D., Medical Director of the Ford Motor Company,

(Continued on Page 564)

specifically for reduction of overweight



PRELUDIN[®]

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"...a highly effective and safe appetite suppressant..."

Based on clinical reports, PRELUDIN produces more than twice the weight loss achieved by patients receiving a placebo.² It is singularly free of tendency to produce serious side actions, as well as stimulation.¹⁻³ PRELUDIN imparts a feeling of well-being that encourages the patient to cooperate willingly in treatment.¹⁻³

The reduced incidence of side actions with PRELUDIN makes losing weight more comfortable for the average patient, facilitates treatment of the complicated case and frequently permits its use where other anorexiant are not tolerated.³

Recommended Dosage: One tablet two to three times daily one hour before meals. Occasionally smaller dosage suffices. On theoretical grounds, PRELUDIN should not be given to patients with severe hypertension, thyrotoxicosis or acute coronary disease.

(1) Holt, J. O. S., Jr.: *Dallas Med. J.* 42:497, 1956. (2) Gelvin, E. P.; McGavack, T. H., and Kenigsberg, S.: *Am. J. Digest. Dis.* 7:155, 1956. (3) Notenshon, A. L.: *Am. Pract. & Digest Treat.* 7:1456, 1956.

PRELUDIN[®] (brand of phenmetrazine hydrochloride). Scored, square, pink tablets of 25 mg. Under license from C. H. Boehringer Sohn, Ingelheim.

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HEART BEATS

(Continued from Page 562)

was appointed chairman of the Community Service and Education Committee, one of the Association's major committees. He will continue to serve on the Board of Trustees and the Executive Committee.

Other Association officers elected were:

Vice President—Mr. Frank N. Isbey, Detroit
Vice President—Mrs. James McEvoy, Detroit
Vice President—Mr. J. William Hagerty, Detroit
Vice President—Mr. Cyrus H. King, Detroit
Vice President—Donald S. Smith, M.D., Pontiac
Vice President—Milton Shaw, M.D., Lansing
Secretary—Robert E. Fisher, M.D., Battle Creek
Treasurer—Mr. Alfred T. Wilson, Detroit

The following persons were elected to the Board of Trustees for a three-year term:

Mr. Don Ahrens, Bloomfield Hills
J. K. Altland, M.D., Lansing
Mr. Earnest Bennett, Detroit
Muir Clapper, M.D., Detroit
Moses Cooperstock, M.D., Marquette
Leon DeVel, M.D., Grand Rapids
F. D. Dodrill, M.D., Bloomfield Hills
Douglas Donald, M.D., Detroit
H. M. Golden, M.D., Flint
John Keyes, M.D., Pleasant Ridge
Mr. Richard Krafve, Dearborn
Mrs. Fred Miner, Flint
Donald S. Smith, M.D., Pontiac

Members of the Board of Trustees elected to serve on the Executive Committee were:

M. S. Chambers, M.D., *Chairman*, Flint
Paul S. Barker, M.D., Ann Arbor
Sidney E. Chapin, M.D., Dearborn
Warren B. Cooksey, M.D., Detroit
F. D. Dodrill, M.D., Bloomfield Hills
Mr. J. William Hagerty, Detroit
E. A. Irvin, M.D., Dearborn
Mr. Frank N. Isbey, Detroit
Mr. George A. Jacoby, Detroit
F. D. Johnston, M.D., Ann Arbor
L. Paul Ralph, M.D., Grand Rapids
Donald S. Smith, M.D., Pontiac
Henry L. Smith, M.D., Detroit
Frank Van Schoick, M.D., Jackson
Mr. Alfred T. Wilson, Detroit

Dr. Chambers, following his election, made the following Standing Committee Appointments:

RESEARCH COMMITTEE

Donald S. Smith, M.D., *Chairman*, Pontiac
F. D. Johnston, M.D., *Vice Chairman*, Ann Arbor
Paul S. Barker, M.D., Ann Arbor
Bert M. Bullington, M.D., Saginaw
Muir Clapper, M.D., Detroit
F. A. Collier, M.D., Ann Arbor
Douglas Donald, M.D., Detroit
John Keyes, M.D., Pleasant Ridge
John Littig, M.D., Kalamazoo

COMMUNITY SERVICE AND EDUCATION COMMITTEE

E. A. Irvin, M.D., *Chairman*, Dearborn
Sidney E. Chapin, M.D., *Vice Chairman*, Dearborn
Muir Clapper, M.D., Detroit
Robert E. Fisher, M.D., Battle Creek
Scott T. Harris, M.D., Ypsilanti
L. Paul Ralph, M.D., Grand Rapids
D. Emerick Szilagyi, M.D., Detroit
Silas Wiersma, M.D., Muskegon
Mr. Paul F. Witte, Grosse Pointe

FINANCE COMMITTEE

Mr. Frank N. Isbey, *Chairman*, Detroit
Mr. J. William Hagerty, *Vice Chairman*, Detroit
F. D. Dodrill, M.D., Bloomfield Hills
E. A. Irvin, M.D., Dearborn
Mr. George A. Jacoby, Detroit
Mr. Cyrus H. King, Detroit
Donald S. Smith, M.D., Pontiac
Henry L. Smith, M.D., Detroit
Mr. Alfred T. Wilson, Detroit

WHAT THE FUTURE HOLDS FOR GENERAL PRACTICE

(Continued from Page 560)

was the moderator for the afternoon session. The six nationally known authorities who discussed traumatic injuries and their treatment were: Kenneth H. Abbott, M.D., Professor of Neurosurgery, Ohio State University; Edward J. Beattie, Jr., M.D., Professor of Surgery, University of Illinois; John H. Powers, M.D., Professor of Surgery, Columbia University; David M. Bosworth, M.D., Professor Orthopedic Surgery, New York Polyclinic; Allen S. Russek, M.D., Professor of Clinical Physical Medicine, New York University; and Harry H. Wagenheim, M.D., Director, Psychosomatic Service, Temple University.

At the conclusion of the scientific program, there was an elaborate cocktail party and reception, with strolling musicians, for the guest speakers, Officers of the Academy, and all registrants.

MSMS ANNUAL MEETING

September 25-26-27, 1957

Civic Auditorium, Pantlind Hotel,

Grand Rapids

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A new
therapeutic approach
with inherent safety
in PRURITUS ANI

HYDROLAMINS®

TOPICAL AMINO ACID THERAPY



Unique physiologic barrier—topical amino acids—brings rapid relief (98%¹) and complete healing (88%¹)

"...the objectives of therapy in pruritus ani can be listed under 3 headings:

- (1) **relieve itching:** [Hydrolamins produced immediate relief of intractable itching in 98% of patients. The anti-pruritic effect of one application lasts about twenty-four hours.¹]
- (2) **accelerate healing,** [Hydrolamins rapidly and completely healed reddened, fissured, macerated and ridged perianal lesions in 88% of cases.¹]
- (3) **allow natural healing without trauma due to physical, chemical, allergic, or microbiologic agents."**² [The amino acids of Hydrolamins promote safe, natural healing while the ointment protects the perianal area from irritation.¹]

Due to the rapidity of action of Hydrolamins, it is believed that protein-precipitating irritants, responsible for the pruritus, are neutralized. Hydrolamins also forms a biochemical barrier against further irritation.

SUPPLIED: In 1 oz. and 2.5 oz. tubes.



Pharmaceutical Company, Chicago 14, Illinois

1. Bodkin, L.G., and Ferguson, E.A., Jr.: Successful Ointment Therapy for Pruritus Ani, *Am. J. Digest. Dis.* 18:59 (Feb.) 1951.

2. Fromer, J.L.: Dermatologic Concepts and Management of Pruritus Ani, *Am. J. Surg.* 90:805 (Nov.) 1955.

AMA Washington Letter

THE MONTH IN WASHINGTON

By approximately the mid-term point in its first session, the 85th Congress had shown enough interest in health legislation to hold a variety of hearings, but there was no evidence that many major bills would be passed before adjournment.

Actually, it was not until three months after the session opened that the Administration sent up to Congress two bills it regards as important—one would change the doctor draft act and the other would authorize small commercial companies to pool part of their resources to stimulate expansion and experimentation in health insurance.

Even then, the Department of Health, Education, and Welfare had not released its draft of legislation for federal grants to medical, dental and osteopathic schools for construction and equipment. On this, there was some reluctance to act until Capitol Hill had decided on the administration's bill for U. S. aid to general education.

Of all these bills, indications were that progress was assured on only one, that providing some revised arrangement for the selective draft of physicians, dentists and "allied specialists." The special doctor draft act, in effect for almost seven years, is scheduled to expire on July 1. Because Defense Department insists it still needs special authority to draft physicians and other professional health personnel by professional classification, the alternative was continuation of a modified doctor draft act or changing the regular draft act.

Meanwhile, a number of other bills had been studied at hearings. They include:

Changes in Medical Aspects of Civil Aviation Regulations.—Witnesses are widely divided on this measure that would set up an Office of Civil Aviation Medicine within the Civil Aeronautics Administration and give the Air Surgeon General who would head the office considerably more authority than now is exercised by U. S. medical officials in this field. There was no official sponsorship of this from the federal governmental level. It was opposed by the Department of Commerce (where CAA is located) and the Civil Aeronautics Board. However, support came from the outside, including testimony from Dr. Jan Tillisch of the Mayo Clinic, Dr. William Ashe, chairman of the department of preventive medicine, Ohio State University, and Dr. Herbert F. Fenwick, president of the Civil Aviation Medical Examiners. Dr. Tillisch headed an AMA ad hoc committee that had started a study of the problem, but he testified as an individual.

Veterans Medical Care.—The House Veterans Affairs Committee had held extensive hearings on a bill to further restrict admission of non-service connected cases to Veterans Administration hospitals, but there were no developments beyond that to encourage sponsors of this legislation.

Civil Defense Reorganization.—Here again a wide split developed at the hearings on just how to reorganize the federal government's participation in civil defense. The Administration wanted to strengthen the U. S. civil defense arm (the Federal Civil Defense Administration), but without going to the extent of making a cabinet-rank Department of Civil Defense, which is the goal of Chairman Chet Holifield (D., Calif.) of the subcommittee that had studied civil defense for more than a year.

Control of Barbiturate and Amphetamine Drugs.—The objective of bills before the House Interstate health subcommittee is to extend federal control to take in the manufacture, compounding, processing, distribution and possession of habit-forming barbiturates and amphetamines. This would be achieved by demonstrating that intrastate control of the drugs is essential to achieve interstate control, a philosophy advanced for years by some federal officials.

While manufacturers, compounders, processors and handlers would have to list their names and places of business with HEW and to maintain complete records, physicians would not have to comply with these regulations.

Pressures for economy that had been evident early in the session seemed to lose their effectiveness when Congress really set to work on the budget for the Department of Health, Education, and Welfare. Whereas in first (non-record) votes the House cut scores of items, it simply reversed itself when roll-call votes were demanded in the final go-around.

As an example, no reductions at all were made in funds for the research institutes, \$50 million was restored for grants to help build water pollution treatment plans, \$1.3 million was restored to the Food and Drug Administration. A \$5 million cut in money for general public health grants to states was sustained by the House—but this money will have to be provided later if the House

(Continued on Page 568)



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(Continued from Page 566)

estimate of the extent of the obligation proves too low.

Economy advocates tried without success in the House to cut \$21 million off money for the Hill-Burton hospital construction program.

While in theory the Senate is privileged to make its own cuts in a money bill coming to it from the House, in practice the Senators generally restore much of the money cut by the House and occasionally (as last year) vote large boosts over House figures. So the possibility now is for even higher health and medical budgets before the appropriations bills finally are enacted.

AMA NEWS NOTES

DAVID ALLMAN TO ASSUME PRESIDENCY IN JUNE

The American Medical Association's presidential oath of office will be administered to David B. Allman, M.D., of Atlantic City, N. J., in impressive ceremonies at 8:30 p.m., Tuesday, June 4, in the grand ballroom of the Waldorf-Astoria Hotel, New York. Besides Dr. Allman's inaugural address, the program will also feature musical selections by the United States Army Chorus, Washington, D. C.; remarks by out-going President Dwight H. Murray, M.D., of Napa, Calif., and presentation of the Distinguished Service Award to the recipient selected by the House of Delegates.

A portion of the inaugural ceremony—from 9 p.m. to 9:30 p.m.—will be telecast over New York station WABD, Channel 5.

Immediately following the ceremonies, Dr. and Mrs. Allman will receive physicians, exhibitors and guests at the annual reception in the east ballroom. The presidential ball will begin at 10 p.m. and continue until 1 a.m. in the grand ballroom.

CIVIL DEFENSE CONFERENCE IN JUNE

Medical aspects of radiation hazards will be the principal topic of discussion at the fifth annual National Medical Civil Defense Conference to be held Saturday, June 1, in the Sert Room of the Waldorf-Astoria Hotel, New York. Sponsored by the AMA's Council on National Defense, the one-day meeting has been designed primarily for representatives of state, local and national civil defense committees, physicians and other leaders of health and medical care facilities. A special feature of this year's program will be reports by Federal Civil Defense Administration officials on plans for handling national civil defense programs and meeting radiation hazards.

Also on the program will be presentations on the effects of radiation and the medical management of radiation casualties, an FCDA film on "Treatment of Nerve Gas Casualties," and an FCDA radiological exhibit.

Physicians planning to attend the AMA's 106th An-

nal Meeting are urged to come a day or two earlier for this worthwhile civil defense meeting. Further details may be secured from the Council.

WIVES PLAN BANG-UP NEW YORK SESSION

More than 3,000 physicians' wives are expected to gather at New York's Roosevelt Hotel, June 3-7, for the 34th annual convention of the Woman's Auxiliary to the AMA. An interesting program, combining business with pleasure, is being arranged by the committee on arrangements, under the direction of Mrs. Harry F. Pohlmann, Middletown, N. Y., and Mrs. Elliott V. B. Vurgason, Baldwin, N. Y. National committee meetings and round table discussions will be conducted June 1-3 with the formal opening of the convention slated for Tuesday morning, June 4.

Business sessions on Tuesday and Wednesday will be devoted to state and national committee reports and discussions of current health projects. Tuesday's luncheon, honoring past presidents, will feature an address on "Sick People in a Troubled World" by Dr. Howard Rusk, professor and chairman of the department of physical medicine and rehabilitation, New York University, Bellevue Medical Center.

Principal speaker at Wednesday's luncheon in honor of the president (Mrs. Robert Flanders of New Hampshire) and president-elect (Mrs. Paul C. Craig of Pennsylvania), will be Dr. Dwight H. Murray, immediate past president of the AMA. At this session, Mrs. Flanders will present the Woman's Auxiliary contribution to the American Medical Education Foundation, and Dr. George F. Lull, AMEF vice-president, will present AMEF awards to auxiliaries.

Election and installation of national officers will be held on Thursday morning with adjournment scheduled for noon. Climax of the convention activities will be the annual dinner for members, husbands and guests in the grand ballroom of the Roosevelt Hotel, Thursday evening. Mr. Allen Richard Foley, professor of history at Dartmouth College, will speak on "Vermont Humor."

The latest population figures for Michigan are 7,300,000, making her the seventh among the states. Michigan ranks fourth in tourist and resort business—\$600,000,000.

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Citrus Bioflavonoid Compound*	100 mg.
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Thiamine Mononitrate (B ₁)	3 mg.
Riboflavin (B ₂)	3 mg.
Pyridoxine HCl (B ₆)	3 mg.
Vitamin B ₁₂ (cobalamin concentrate)	3 mcg.
Niacinamide	25 mg.
d, Calcium Pantothenate	5 mg.
Folic Acid	0.5 mg.
Menadione (K)	1 mg.
Vitamin E (dl, alpha tocopheryl acetate)	1 Int. Unit
Magnesium	3 mg.
Manganese	1 mg.
Copper	1 mg.
Zinc	1 mg.
Molybdenum	0.2 mg.
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Cobalt	0.1 mg.

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Editorial Opinion

BLUE SHIELD LEAVES LOW-VAULTED PAST

In February, 1942, when the Council of the Massachusetts Medical Society approved the recommendation of the Committee on Public Relations to establish a fee table for Blue Shield service benefits, an income level of \$2,500 per family was set as a ceiling. Subscribers with family incomes over \$2,500 a year would be reimbursed up to the scheduled amount, and pay the surgeon the balance of his normal fee out of their own pockets.

This ceiling of \$2,500 family income was chosen, not on the basis of medical indigency or inability to pay, but as a selling device. It was necessary to enroll the largest possible number of persons. A study of family-income levels had shown that in the period 1935-1939, which was assumed to be "normal" (although actually it was a period of severe depression), 91.4 per cent of the wage-earning group had a family income of less than \$2,500 a year (40.6 per cent received from \$750 to \$1,000 a year, 42.8 per cent from \$1,000 to \$2,000, and 8 per cent from \$2,000 to \$2,500). Thus if enrollment of all families earning less than \$2,500 was permitted, 91.4 per cent of the wage-earning population (about 1,200,000 persons) could be included as a potential market for prepaid medical-insurance policies.

Instead of returning to "normal" after World War II, wages and prices continued to increase, and in February, 1947, the Council agreed to set the ceiling at \$3,000, in view of the higher cost of living, although no corresponding increase in fees (to correspond with the coincident increase in wages) was voted.

By 1950, it was apparent that something was wrong. At the February meeting of the Council figures were presented showing that in 1948 the number of families with incomes of less than \$1,000 had dropped from the 1935-1939 level of 40.6 per cent to 8 or 10 per cent, and that those with incomes of \$1,000 to \$2,000 had fallen from 42.8 per cent to about 14 per cent. The cost of living had gone up at least 6 or 8 per cent since 1935-1939, and wages had risen correspondingly, so that more than half the population now had annual family incomes between \$2,000 and \$5,000. To reach even 80 per cent of wage earners, service benefits would have to be extended to all persons earning up to \$5,000 a year.

A blue-chip group was therefore set up, and on February 1, 1950, the Council approved a secondary fee schedule of service benefits 50 per cent higher than the old one, for persons with incomes over \$2,500 but under \$5,000, to be known as

Plan B. This would cover 80 per cent of the population and only the 20 per cent with incomes over \$5,000 would be subject to additional charges by the surgeon, to meet his standard fee.

It is now again proposed to raise the family-income ceiling for service benefits to \$7,500, below which the physician will accept the Blue Shield fee as his total fee. The Executive Committee of the Massachusetts Medical Society (voting members of Blue Shield) have approved raising the ceiling to this figure, and the increase has been accepted by the Council.

Department of Commerce figures show that families with incomes under \$1,000 (as of 1955) constituted only 1 per cent of the population (as contrasted with 40.6 per cent in 1935-1939), and those with incomes of \$1,000 to \$2,000 only 3 per cent (as compared with 42.8 per cent of all families in 1935-1939). To reach 1,200,000 persons today, Blue Shield must cover 60 per cent of the working population. But 60 per cent of families now enjoy incomes between \$3,000 and \$15,000. Only 9 per cent have less than \$3,000 a year; 49 per cent have between \$3,000 and \$7,500, and 42 per cent have incomes in excess of \$7,500.

Average family income, which was \$2,340 in 1930, had risen to \$5,520 in 1955, an increase of 136 per cent. The cost of living rose over a similar period about 90 per cent.

Blue Shield fees to doctors under Plan A, in spite of these tremendous rises in family income and in the general cost of living, have remained constant, and until now there has been little change in the Plan B schedule since its authorization in 1950. Although the consumers' index shows an increase in cost of living of 12 per cent over the period 1950-1956, there has been no such general rise in Blue Shield Plan B fees.

Careful study and re-evaluation of cost-of-living indexes, fee schedules and subscribers' rates must accompany the proposed rise in the ceiling for service benefits to \$7,500. Otherwise, dissatisfaction with Blue Shield fees will continue to increase, and it will become increasingly difficult to explain to Blue Shield subscribers why their insurance does not cover their medical and surgical bills.

Fortunately, this process of study and re-evaluation is under way, and to some extent already in effect. For example, the Medicare table of fees, which the members of Blue Shield have accepted as a basis for a new Plan B schedule, includes instead of the meager current fees for medical (as distinguished from surgical) care, such items as

(Continued on Page 658)

in Hay Fever or Asthma . . .

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Tasty INCREMIN is available in either Drops or Tablets. Caramel-flavored Tablets may be orally dissolved, chewed or swallowed. Cherry-flavored Drops may be mixed with milk, formula or other liquid. Tablets: bottles of 30. Drops: plastic dropper-type bottle of 15 cc.

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l-Lysine 300 mg.
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Tolerance to this combination is good because there is little likelihood of sodium retention, potassium depletion or gastric distress with buffered prednisolone, and meprobamate rarely produces significant side effects in therapeutic dosage.

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INDICATIONS: A wide variety of conditions, in which four symptoms predominate: *a*) inflammation *b*) muscle spasm *c*) anxiety and tension *d*) discomfort and disability; i.e., rheumatoid arthritis, rheumatoid spondylitis (Marie-Strümpell disease), Still's disease, psoriatic arthritis, osteo-

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	relieves pain	suppresses inflammation	relaxes muscle	eases anxiety	imparts sense of well-being
Salicylates	✓	✓			
Muscle relaxants			✓ ¹		
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Steroids	✓	✓			✓
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arthritis, bursitis, synovitis, tenosynovitis, myositis, fibrositis, fibromyositis, neuritis, acute and chronic low back pain, acute and chronic primary and secondary fibrositis and torticollis, intractable asthma, respiratory allergies, allergic and inflammatory eye and skin disorders (as maintenance therapy in disseminated lupus erythematosus, periarteritis nodosa, dermatomyositis and scleroderma).

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583

Recent Observations

On Self-Regulated Schedules For Infants

Genetically acquired behavioral predispositions enable the normal baby to regulate its feeding intake and periodic hunger sensations, its feeding habits. These physiological regulatory forces may be satisfied by adapting the formula content and feeding period to the individual needs of the infant. It involves a sensible compromise between too rigid a schedule, geared to the clock and too lax a schedule, based on self-demand feedings. Such is the current objective: for either extreme can lead to infant feeding difficulties.

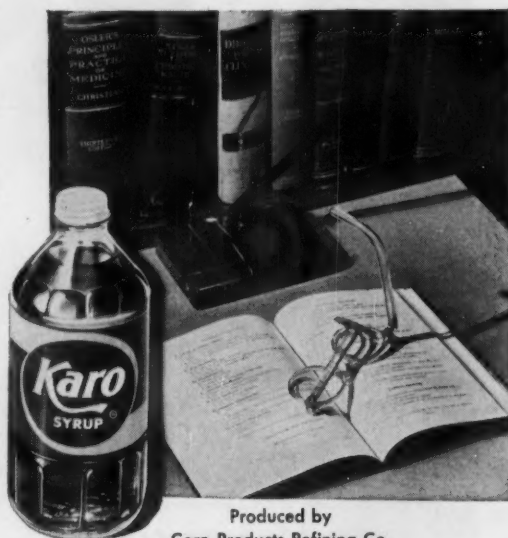
The newborn may become a feeding problem if the prescribed formula is excessive or the feeding schedule rigid. Every time he is awakened abruptly from satisfying slumber to be fed forcefully, the baby gradually loses his enthusiasm for the food and begins to resist the feeding. The young infant may balk at the crude introduction of a new food or feeding procedure without the proper prelude of gradual adaptation of taste, color, consistency and quantity.

The older infant weaned from bottle to cup may reject milk or go on a hunger strike. Devoted to his bottle he resents its sudden deprivation. It takes a certain readiness for weaning to make that change agreeable. Later the infant becomes somewhat independent of his mother and arbitrary with his food. What he enjoyed yesterday, he rejects today. If he distorts the diet for a day and his mother resorts to force, a feeding problem is in the making. Sensible decorum will solve these

little difficulties before they become big behavior disturbances in childhood.

The problems of infant feeding are always the same but solutions may differ with each era. The carbohydrate requirement for all infants is as completely fulfilled by KARO® Syrup today as a generation ago. Whatever the type of milk adapted to the individual infant, KARO may be added confidently because it is a balanced mixture of low sugars, easily mixed, well tolerated, palatable, hypoallergenic, resistant to fermentation, easily digestible, readily absorbed, non-laxative. Readily available in all food stores.

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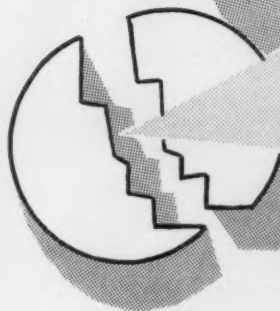
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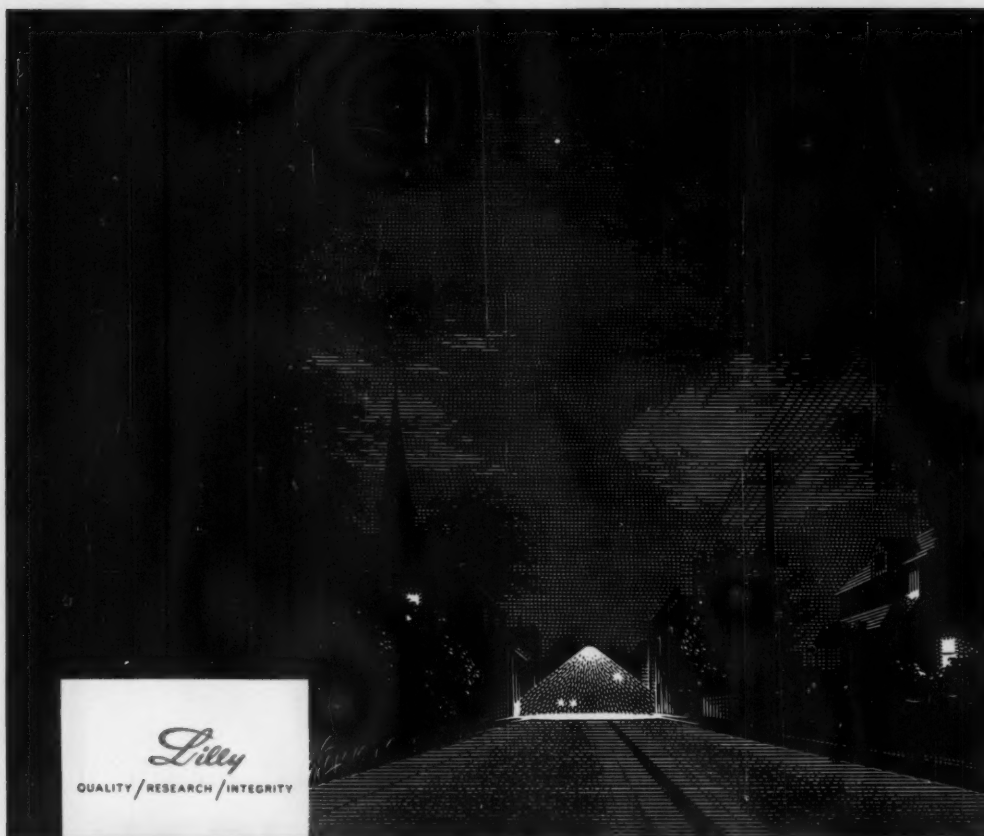
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Preventive Geriatrics

Importance of Good Nutrition and Exercise in the Aged

THE GERIATRICS Committee of the Michigan State Medical Society has by meeting, study, consultation and collaboration accumulated some important information and opinion that it feels should be made available to the men of medicine in the State of Michigan. This series began in 1954 with the first group article entitled "Preventive Geriatrics."

The Committee believes that its most important work is in the field of prevention. Since the concept of prevention stands out in the material to be presented, it was decided to continue the group article again under the heading of "Preventive Geriatrics." Instead of ranging through the entire field of medicine, as was done in the last article, it was decided to limit the discussion to nutrition, physical development, education and exercise. A panel discussion was conducted by mail between the members of the Committee and outstanding authorities in their respective fields. What follows is the thinking of this Panel. The members of the Panel and the Committee are appended.

A discussion of nutrition fits "hand in glove" with a discussion of physical exercise. In many of the opinions expressed below, there is a distinct overlapping of these two fields. This is the type of thing that we expect and encourage; but for purposes of simplification the first part of this paper will deal largely with physical education and physical exercise, the second part will deal with nutrition.

In the "Preventive Geriatrics" number of THE JOURNAL OF THE MICHIGAN STATE MEDICAL SO-

CIETY of May, 1954, Dr. Michael M. Dacso and Howard A. Rusk as a part of their contribution to the panel discussion offered the following:

"In a previous publication, 'Clinical Problems in Geriatric Rehabilitation'; one of us gave a practical, clinical classification of the geriatric patients who can benefit from rehabilitation:

1. Obviously handicapped patients (hemiplegia, arthritides, fractures, amputations, and neuro-muscular disease).
2. Those chronically ill without signs of manifest disability (chronic cardiac disease, chronic pulmonary diseases, et cetera).
3. The elderly persons who are not obviously ill, but have impaired physical fitness.

"It is in the third group that the preventive aspects of rehabilitation are presently most neglected. In many cases, the self-imposed, illogical and unnecessary physical inactivity, together with an insufficient diet will cripple the older patient without any underlying pathologic condition. The physical medicine and rehabilitation specialist is prepared to evaluate objectively the patient's physical capabilities and, if need be, improve them with properly applied and graded physical activities.

"A more intensive concentration on this third group of patients could prevent a great number of them from needlessly crossing the line between a useful and physiologic senescence and a useless and burdensome senility."

In the treatment of the above-listed groups, good nutrition, various types of mechanical devices and prosthesis and surgical procedures are necessary to bring a degree of improvement. The one item of treatment that is common to all three groups is graded, passive and active exercises to

improve the tone and the function of the parts affected. Accepting the last statement of the quotation, as an obvious truth, it would seem that an earlier application of the same principle to the youth of the land would be helpful in providing longer, more healthful years for the human body.

Dr. Laurence E. Morehouse of the University of California, participating in a radio broadcast entitled "The Sitting Man," aided in making the following contribution:

"Ring Lardner once said, 'The only exercise I get is when I take the studs out of one shirt and put them into another.' It can be assumed that this was intended as a facetious remark, but there are a good many American adults who could honestly match it with a record of physical activity not much more rigorous. The office worker in the big city rides to work in the morning by auto, streetcar, or bus. If he drives, he may lose his temper a few times, but that isn't exercise. At the office he sits at his desk most of the day. Perhaps his principal exertion is picking up the telephone. He rides back home in the evening, and reads the paper before dinner. After dinner, he may watch television, listen to the radio, read, or lie down on the sofa for a nap. On the week end his recreation often consists of taking a ride into the country—in an automobile.

"The increasing use of automobile transportation has worried some observers, and some years ago one prophet predicted that eventually our legs would wither away in a few generations if we didn't use them more. So far this hasn't happened, but apparently the modern conveniences have made some inroads on our general stamina. In a recent issue of the *New York Times*, Jean Mayer of Harvard University has stated flatly that Americans are getting soft. He points to the fact that rejection by the draft on grounds of general lack of fitness reached fifty per cent, and he says that American men are steadily growing heavier for their height and age—reflection of rich diet and easy living. Even children show this trend toward softness. Our success at sports can be partially written off when the small number of men on the football or baseball team is compared to the huge crowd sitting in the stands or slouched in an easy chair at home watching the little screen.

"If physical stamina and health were of no importance, the unfavorable statistics could be disregarded. But most people realize the need for keeping in reasonably good physical condition even if they don't do anything about it."

Farther along in the radio script it was pointed out that Dr. Morehouse had learned that young management executives in conference felt that the lack of physical fitness handicapped them in their deal with labor. They admitted that lack of stamina worked against them in long and grueling bargaining sessions with labor leaders. When they met these men across the bargaining table,

the labor leaders would bring up minor points in the proposed contracts and haggle over them for hours at a time. Although the executives tried to keep alert by drinking coffee from time to time, eventually they grew tired and reached the point of fatigue. It was then that the labor leaders introduced the critical bargaining points and forced the major concessions. When labor representatives were later asked about this strategic technique, they freely admitted that it was often used to great advantage. Both labor and management executives recognized that if they were in better physical shape, they might be better able to withstand physical and mental fatigue in the long bargaining sessions.

This problem raised the question of whether or not physical condition is a critical factor in the ability to preserve mental alertness and efficiency under stress. In an attempt to find the answer, a small research program was established in Harvard's Fatigue Laboratory using twenty professors as the subjects of the experiment. The men were first given a complete physical examination, which included the functioning of their nervous systems and blood circulation. Then they embarked on a prescribed program of light exercise, work, and rest. Attention was also given to such factors as proper nutrition.

Again the results were favorable. Part of the estimate of these results depended on subjective evidence—that is, the self-evaluations of the subjects engaged in the experiment. But measurements in the laboratory bore out this personal testimony. When the experiment began, the subjects were thrown off balance by the slightest stress. As the program progressed, it was found that the subjects reached the point where they could undergo certain amounts of stress without becoming mentally upset.

Dr. Morehouse found in this and in other experiments that many executives are as much a slave to routine and detail as the youngest apprentice in the business. They are adrift on an endless sea of paper work, and they never seem to reach shore. They accept whatever responsibilities are placed on them without any self analysis of their time or ability to fulfill them adequately. Thus they are constantly harassed and have little time for creative thought and effort. One of the results is that executives fail to take out enough time for recreation or for doing the things they really want to do. Often they

look forward to retirement as a time when they can do what they have always wanted to do. But, unfortunately, some of them never reach the retirement age.

Dr. Morehouse is a strong advocate of enjoying life as you go along, even though this requires a bit of organization and planning. It involves allowing time for rest periods and for reasonably leisurely meal times. And, it involves some attention to physical fitness, even if the time devoted to exercise is no more than two or three ten-minute periods a week. It isn't necessary for the sedentary white collar man to be in the same kind of physical condition as the professional football player. An office worker who attempted to keep in this kind of shape would be considerably over-trained. But his physical condition should be slightly in advance of his actual needs. Just as a baseball player can't keep in shape just by showing up for the games, neither can a file clerk stay in condition merely by opening and closing the files. There is no clear cut relationship between exercise needs and age. A person who has been accustomed to vigorous physical activity all of his life may still be as capable of exercise at seventy as the sedentary man of forty.

Dr. A. Hazen Price, Chairman of the Geriatrics Committee, in his introduction of the topic for discussion, had this to say regarding physical exercise:

"Even though there is overwhelming evidence to indicate that graduated, physical exercise is essential for the maintenance of a healthy body, there are very few people who regularly follow this practice. We all recognize that some form of activity out of doors stimulates the appetite and promotes more restful sleep. It provides a sense of well-being unequalled by any other type of exercise. When this type of activity is not possible, then some type of setting up exercise indoors helps increase total body metabolism as well as accelerate our general circulation, increase body temperature and prevent a great deal of mental sluggishness. Nerve tension is lessened, exercise serving as an outlet for pent-up pressure. We are all aware of what happens to the arm or leg kept immobilized too long in a cast. Sitting or standing for long periods without some activity creates a stiffness and aching of joints when motion is attempted. Early ambulation, postoperatively and following childbirth, decreases the period of convalescence, as well as lessening the likelihood of peripheral phlebothrombosis and pulmonary stasis. Less prolonged bedrest after cardiac infarction has likewise decreased the incidence of thrombo-embolic complications to say nothing of improving the patient's outlook psychologically.

"If we admit that these statements are true, would it be unreasonable to apply the principles involved in order that we keep well? It must be stressed that the type and the amount of exercise should be adapted to the age and physical fitness of the individual. If it is done in the form of recreation, particularly with one or two companions, it will not only improve muscular tone but also have an excellent tonic effect on morale. Exercise should be fun, and not done just because it is good for us.

"Those people who have always been active physically should be encouraged to continue some form of activity, regardless of age, decreasing, of course, the intensity of the physical effort with the years, or if disability intervenes. Some regular and systemic exercise each day will help the individual 'meet daily tasks with a better body and a more alert mind.'"

Dr. C. Howard Ross, a member of the Geriatrics Committee, adds:

"Activity brings joy to the heart and solace to the mind. In many rehabilitation programs, every muscle and joint, that has the power to wiggle, must be made to wiggle more, and eventually bring the patient to the level of self-care. With very few exceptions, there should be a daily physical exercise program for every one in this world."

Dr. C. Etta Walters of Department of Physical Education for Women of the Florida State University, Tallahassee, Florida, writes:

"During World War II, when bed space was limited and medical care needed to be expedited, we evoked a well known, but much neglected principal in exercise physiology, e.g., that structure demands function, while disuse promotes atrophy. Instead of prolonging the bed rest after the acute phases of treatment, patients were put on their feet as soon as possible and exercise was the usual recovery procedure. DeLorme's 'Progressive Resistance Exercise Program' came into vogue, and the work of Hellebrandt and Kabat as well as those of others did much to provide and explain the physiological mechanism upon which these exercises rest. Thus the physiological basis of the 'Overload principle' or 'Progressive Resistance Exercises' has provided the rationale for the treatment of the physically incapacitated and the maintenance and achievement of strength and endurance in the normal. This principal demonstrates that the organ systems of the body that are pushed to levels beyond those which can be easily met are the ones that develop the capacity to perform more efficiently. An experimental demonstration of this in regard to the cardiovascular system was performed by Christensen some years ago. He trained men to perform progressively heavier work on the bicycle ergometer and studied the heart rate and the stroke volume response. If, after having reached a constant value for heavier load the subjects returned to the lighter one, it was performed with a lower heart rate and a larger stroke

volume than when the same work had been performed initially. This is such a commonplace occurrence in the development of cardiorespiratory endurance and muscular strength that we are apt to ignore its implication for the importance of activity in daily living. The literature in the past ten years has pointed out some of the evils of prolonged bed rest and, therefore, has shown further the dangers inherent in inactivity.

"Inflexibility can be as incapacitating as can inadequate strength and endurance and some of the pains associated with advancing age can be trained to muscle tightness. Tight muscles can always cause irreversible changes in body structure and thus a functional defeat can become a structural one.

"Whether we exercise for the sake of activity or whether we do so by indulging in a favorite pastime which employs it, the important fact is that exercise when properly directed does increase the efficiency of the body in performing normal every day activities and enables it to meet emergencies with a minimum change in the homeostatic functions of the body. Although it is not essential, and sometimes inadvisable, that the older person indulge in strenuous activities of his youth, Jokl has shown that the deterioration of performance usually accompanying age can be prevented by regular training. We are conditioned by our interest and habits acquired in childhood and, therefore, it is important to develop early a love for activity and skills that will give to us good behavior patterns in terms of exercise in later life.

"It is important to educate the older person in the value of exercise and recreational interest. We must also provide opportunities for him to pursue such activities and our cultural pattern must recognize that senescence and inactivity are not synonymous."

Since the type and amount of physical exercise tolerated by any individual should be in the form of a prescription to fit that individual, and should be continued with appropriate modification throughout life, Dr. C. H. McCloy of the Division of Physical Education and Intercollegiate Athletics of the State University of Iowa thinks that "there should be more emphasis on medical examinations than is common at present." He suggests:

"First, I think that the medical societies should make a point of making clear to medical practitioners what it is that constitutes an adequate examination. I have had medical examinations myself covering the last twenty years, and some of them were so poor that they were not worth the time spent on them. Some were excellent.

I think that some practitioners either do not know what constitutes an adequate examination or they feel that they cannot charge enough for an examination to justify their giving it and, hence, give the individual examined the full sense of security although they do not do a thorough job. I think the medical society

could well go on record as to what constitutes an adequate physical examination.

"Along these lines, I think that one thing should be added to the examination, probably starting about the age of forty. This item is the examination for blood cholesterol . . . in view of the large number of deaths due to coronary occlusion, I think this item could very well be added. I realize that most practitioners in small communities have no facilities for analyzing the blood for cholesterol, but it is quite possible to draw the blood and preserve it and send it to the state laboratory.

"I think it would be a distinct service to indicate what aspects of a medical examination need to be done each year or oftener (for example, as one gets older, it is perhaps desirable that the prostate be examined every six months). Dr. C. Ward Crampton believes that certain aspects of the medical examination need not be done very frequently. Others need to be done with a great deal of care, quite frequently. It would seem that this possibility should be explored. If the same physician is doing the examination, has access to his previous records, a great deal of time and expense could be saved.

In this part of the panel discussion which had to do largely with generalities of the whole problem, Dr. Ernest D. Michael of the University of California said:

"If aging is concerned with both the physical and the mental processes, it seems that some form of preventive medicine should be tried that will stimulate the physical vigor as well as the mental desire for activity. This implies that the physical activity which I feel is necessary for healthful living, must be pleasurable. Of the many forms of physical activity, the best from the standpoint of interest usually concerns combination of exercise and a duty. Competition is found in almost all sports, particularly fishing, bowling, archery, etc. To combine exercise with duty involves a selection of activities, hiking, bicycling and garden activities, which takes a person outdoors in nature.

"A club or organization would be conducive to bringing together people of like interests so that they could participate in these physical activities.

"In addition to the above, there are other means to retard deterioration that recent studies verify. Weight-lifting, done to the rhythm of music might be used to glamorize a sometimes dull activity. Cold showers have been found to stimulate the circulation and reduce fatigue. This also may be a means to stimulate the mental activity and add to the picture."

Dr. Henry J. Montoye of the Michigan State University states:

"My field of interest is the physiology of exercise and I am very much interested in the role for regular physical exercise among middle-aged and older

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people. There is no question in my mind that regular exercise of the proper intensities and duration can do much to postpone the deterioration which commonly occurs as the individual gets older. There are all kinds of cases in the sports world where amazing physical feats have been performed by people well up in years. We do not expect that the average man or woman will in the later decades of their lives accomplish similar feats, but some regular exercise, I am certain, could maintain the physical capabilities of these people at a very much higher level. Furthermore, I think that such regular exercise would affect not only the physical capacity, but their interest in other people and the world about them, their energy for doing mental work and in general, their vim and vigor for carrying out everyday activities.

"There are in the literature age curves permitting physical activities, as for example, a grip strength, flexibility, reaction time, et cetera. However, I am certain these curves can be modified with regular exercise, diet control and other activities. However, I think the two mentioned, namely, regular exercise and diet, can play the greatest part in preventive geriatrics.

"We have an experiment underway at the present time among middle-aged men who are very much out of condition. These data being collected will contribute to our knowledge in this area. However, I think the most dramatic effects of regular exercise among older people insofar as their physical capacities are concerned, will be demonstrated in the cardiovascular area and to a lesser extent in strength, flexibility, co-ordination, reaction time and certain other areas.

Dr. C. Etta Walters further adds:

"While physiologic involution is an inevitable concomitant of aging, proper or improper use of the body can delay or hasten the process in certain cases, and parts of the body. Incorrect body mechanics can cause unnecessary wear and tear. Although people probably stand in the most economical posture in terms of energy cost, it does not follow that they use the best mechanical principals in active postures such as lifting heavy objects, in carrying, reaching, pushing and other similar activities. The high incidence of slipped disks with their accompanying pain attest to this fact. Recent electromyographic evidence has shown that when the trunk is bent forward and a weight lifted, the erector spinae muscles do not participate in the lift, and other muscles of the lower trunk do not seemingly function. Thus the strain is borne by the intervertebral ligaments which cannot often stand the weight imposed. When the trunk is kept upright and centered over the object to be lifted or aligned with the direction of the reach, pull, et cetera, the leg muscles bear the brunt of the weight with help from the back muscles, thus relieving the tension on the ligaments.

"The capacity to maintain an effective homeostasis while performing work has been defined as a measure of physical fitness. Judicious physical training has

been demonstrated to contribute to the maintenance of a more effective homeostasis and there is no reason to believe that it is not as important in the aged as in the young. Physical activity with its resulting effects would have a bearing on any physical examination that included any response to physical stress. Thus, if one kept in good physical condition by exercise, it would be possible for him to maintain a certain degree of fitness with a less rigorous program as he became older.

"It has been known that the psychomotor skills that are developed early and kept in training can be retained by the aged to such a high degree that the older person can surpass a much younger age group in this skill.

"It would appear, therefore, that continued exercise of a skill can be of benefit to the aged as it is not lost, and since physical capacity and endurance can be maintained to a high degree in the aged by regular training, it would seem that exercise and training would be an attribute of all ages. Recreational hobbies such as fishing, gardening, or golfing, brisk walks, and countless others provide a means of maintaining a certain degree of acquired physical fitness. For those unable to participate in this manner, it would be advisable for them to indulge in some form of an exercise program even if within the confines of their home. Physical fitness and endurance can be developed by this method as well as a desirable amount of flexibility of muscles and joints maintained."

From the Department of Physical Education for Women at the University of Wisconsin, Dr. Lawrence Rarick opines that:

"The problem of the aging is at last receiving the thoughtful attention which it rightfully deserves. As has been frequently stated, the first twenty years of life are spent in gaining physiologic equilibrium, the next five to ten years in maintaining the peak level of physical efficiency, followed by the gradual, but continuous process of the physiologic deterioration. Our concern is to lengthen the span of optimal-efficiency and retard the processes of physical deterioration.

"While much remains to be learned concerning the process of aging, we see its symptoms in many persons prior to the middle-adult years. While disease and hereditary factors cannot be disregarded as important factors in bringing on the characteristics of early aging, there is little question that little factors over which the individual has control may predispose him to this condition. A considerable body of evidence now points to unwise dietary habits and physical inactivity as factors which must be given careful consideration.

"There is an increasing body of evidence which indicates that a life of physical inactivity is detrimental to the health of men in the age range of forty-five to sixty-four. This is borne out by data reported by Morris in which it was found that the mortality rate from coronary heart disease for English males was more than twice as high for light workers as compared to

heavy workers in the forty-five to sixty-four age range. Similar, but not so dramatic, differences were found by Morris in regard to the mortality rate from diabetes. According to Krause, 80 per cent of low back pain among persons in middle-adult life is due to inadequate physical activity.

"If the aim of those responsible for guiding the health of the people in the middle and later years of life is to maintain a vigorous, active and productive life, then the importance of an exercise program, suited to the organic capacity of the individual should not be overlooked. Careful medical supervision must be emphasized and assurance given that the organic condition of the individual is appraised regularly. Studies of German men who were athletic in their youth, indicates that continuation of a physically active life can postpone many of the symptoms of aging by as much as twenty to thirty years, with apparently no harmful effect to the individual. These men were able to continue effective performance in their forties, fifties and some in their sixties and early seventies. While the evidence is not clear concerning the effects of exercise on longevity, there is strong support for the belief that the person will have a healthier, happy and more productive span of years late in life, by including a regular program of physical activity in his regimen of living."

Recognizing that this problem involves more disciplines than just the medical, Dr. Janet A. Wessel of Michigan State University writes:

"We need education in our schools and in our clinics for the development of the physical potential of mankind. This is the role of physical education in the schools, to provide guidance, direction, and opportunity for the development of the movement potential for all children. It should be the role of physical education to provide the same for adult education. Physical education should develop within each individual the concept of movement through the years . . . how it changes, the effect of physical activity upon the body, the mind and the motions, why movement or activity seemingly plays such an important part in total fitness or health, in that movement—efficient skillful movement—is not a way of life; but it is life. Movement should be understood from its earliest beginning, through childhood, adolescence, adulthood and the other years. Each person should be aware of his physical potential through the years. Each person should be physically aware of a feeling of being in good physical condition . . . being physically fit. And man must realize that to be truly educated, he must develop his potential in all aspects of his life . . . the mind, the body, the emotions and the spirit. We must begin teaching movement—not games or sports or dance. These things will come as the way of developing the physical potential of man. But games and sports and dance must never take the place of man's understanding of the fundamentals of all movement and the need for movement through the years.

"And what is of more importance to this whole picture is the way one moves . . . adherence to basic principles of movement is important at all ages, and plays a great part in the effect of movement upon the individual. I believe that two-thirds of the people must be taught and directed how to move with ease and grace . . . and this must be done in terms of the life of each individual . . . his particular problems and his inherited capacity. As far as glamour and exercise are concerned . . . what woman, regardless of age, is not interested in her form and figure? Her energies? What man, regardless of age, is not interested in his physique and proud of his muscular exploits as he grows older? His energies? Exercise . . . all movement should be approached from this angle, as well as efficiency and skill. However, I think that attacking the problem of the physical potential in the aging should not be from the prescribed exercise standpoint; but from the broader aspect of movement through the day and the year. I believe that a pamphlet should be put out on Movement Through the Years . . . how it changes . . . and maybe a series of articles on movement in the later years dealing with postural changes, muscular tone, efficiency, energies, movement principles, and ways to adapt yourself to the changing times . . . through your work, your hobbies, your interests, et cetera.

"Maybe some day a Movement Clinic will be set up for the aging to determine their movement needs in life of the total individual. A movement specialist will analyze the individual's total life situation and with consultation of the medical doctor, make recommendations for the improving of the physical potential of his patient . . . this should come from the medical doctor . . . but someone must show the individual how and give him opportunity to practice and this would be the physical educator and/or the physical therapist."

The value of sports to the individual is emphasized in an article titled "The Aging of Athletes and Athletic Longevity" by Dr. A. Bidon, translated from *Le Viellissement Des Athletes Et La Longevite Sportive, Medicine, Education Physique Et Sport*, 2:187-198, 1949, translated by Ross Macnab. Dr. Bidon speaks of his own re-education by means of sports after being discharged from the military service with five major wounds and also his experience of intimate contact and physical examination and observation of some 150 veterans whom he studied, followed and advised. The following quotations from his article conveys the gist of his experience and thinking:

"One may conclude from these examinations that prolonged participation in sports has no detrimental effect on the body."

The men under observation at this time varied in age from thirty-five to sixty-five. Among the

older athletes that were examined. Dr. Bidon noted one point in common:

"All seemed to be fearful of overweight.

"At the onset of the forties or fifties, sport can be an extremely important means of therapy. It may be as a preventive, by strengthening the individual, or as a therapy in certain cases. What are the biggest enemies of people of all ages? They are overweight and cardiovascular or renal conditions.

"Participation in sport after age forty, therefore, must be very progressive. The individual must re-educate his skeletal muscles, as well as his heart, change his way of life, and readapt his body to physical effort.

"A similar danger exists in regard to vacations. So many people feel that they can regain in fifteen days at the beach or in fresh mountain air that which they have lost in 350 days of clogging up and stiffening. Result: The vacation ends with the individual in a horrible physical state. A word here to physicians who will supervise athletic neophytes. The vacation period should be a period of mental rest and discreet physical readaptation, and not a period of athletic debauchery.

"Excesses, such as overeating, causes a much heavier burden than does sport participation.

"I repeat what I said at the National Congress of Physical Education in 1914. Medical control of sports, so necessary in youth, is even more vital in old age."

Dr. Bidon further says:

"I owe much to sport which educated me, and which aided in my re-education after war wounds, just as it has rehabilitated many others. I am confident, on the basis of data I have collected—low blood pressures, the stronger hearts, the slow pulse rate and resistance to overweight—that sport is beneficial. One can easily see that the heart of an athlete will beat fewer times in a lifetime than a heart not conditioned by activity."

Ernest D. Michael of Santa Barbara College, University of California, finds that:

"Regular exercise programs have been found to enhance the body in regard to muscular strength, motor skills, and circulatory improvement. Increases in strength and motor skill has improved the efficiency of movement and helped prevent fatigue caused by physical exertion. The increase in muscular tone also aids the venous return of the blood which in turn augments the circulation. The improvement in circulation is reflected in the slowing down of the pulse rate during training, in the faster return to normal of the pulse rate after exercise and in the improved blood pressure response following the training program.

"Along with the general improvement in fitness, a sense of well-being or a feeling of good health is usually found as a result of exercise. The measure of this is subjective and, therefore, is not accepted by many as reliable data. It is possible that this sense of well-being is emotional in nature and, therefore, is the result of

an adjustment concerning the autonomic nervous system. If this is true, then exercise may prove to be important in man's adjustment to stress involving the autonomic system."

Dr. Edward F. Crippen of the Committee reports:

"I am repeatedly impressed in all age groups by the difference in work capacity or desire to work in individuals with the same physical defects. Thus, physical appraisal is too closely integrated with mental state to be separated.

"More and more as I see patients, I feel one family, 'Brown' clan, can expect more physical fitness at sixty-five than the 'Holcombs,' and if I know the family then I know whether Joe Brown is up to standard. I presume in certain areas the standards at sixty-five change, that must be in the countries or localities with extra long life expectancies.

"'Good for the age' is a crutch used by me and many. It reassures the patient and allows the physician an out should succumb in two weeks. Of course, it doesn't work at twenty, so we don't use it. We always should expect more, for it gives us hope as well as the patient. The answer is whether the added diet, drugs, exercise, et cetera, are worth the effort. Yet the returns may be minute, in comparison to the efforts to obtain them."

In discussing the problem before the panel, Dr. Walter S. McClellan of the University of North Carolina writes:

"All suggested measures of the functional response of older people fail because of the lack of soundly established norms. The functional performance of any test to evaluate function is influenced by so many factors, such as training, ability to co-operate, desire to co-operate or the development of fear and apprehension, that it is very difficult to give a fair and sound evaluation to the test. Again, one may find a considerable variation in the response of the individual under study in repeated tests. No statistical analysis will reveal the reasons for these variations any more than we can give a logical reason for the changes in the function of the joints of an arthritic patient on different days and under conditions of climate and weather. There are no good ways to measure the total functional response of older individuals.

"The variations in functional responses in patients with similar structural defects resides in the initiative of the individual. Everyone is familiar with the great difference in the performance of patients with hemiplegia who show essentially similar lesions. One patient may be confined to bed, another is found in a wheelchair, a third is walking with the aid of a crutch or cane. The main factor which accounts for these variations is the motivation of the patient, which may be called 'desire to get well.' All experts in the field of restoration therapy for these patients recognize the importance of this factor and can show patients who have progressed up the scale of improvement much faster than their structural

defects would seem to indicate was possible when their treatment started. This may be the teachability of the patient, or it may be the degree to which fear complexes can be eliminated by the patient. The physician, the family and friends of the patient can either add to these fear complexes or they may be of the greatest aid in removing these blocks from the patient's therapy pathway.

"Heredity undoubtedly plays a role in the physical status of older citizens. Barring intercurrent acute disease or accident, heredity likely determines, more than purely environmental factors, the length of our life. Our hereditary environment can be influenced by environmental factors toward the shortening of our life span or conversely with the observation of good health habits, it may be possible to lengthen the life span.

"Physical exercise can only contribute to a person's physical state at the time of examination if it has been a regular part of his life's habits, for many years.

"A regular plan of physical exercise properly followed through young adulthood and middle-age, I believe, will provide the older person with a better physical machine.

"Organ systems function more normally when posture is good; i.e., they are sometimes impeded by the mechanical inefficiency of poor posture.

"The motivation required to get people to exercise may be either a desire for perfection or a fear of disability. In older people, the calloused attitudes which largely act toward maintaining the status-quo will prevent the development of any general health exercise program.

"The one exercise which I consider the most beneficial is regular deep breathing. It raises shoulders and chest, improving our posture and our sense of well-being. It helps return the venous blood to the heart, it fills more of the lung alveoli with air and results in improved oxygenation of the blood. This exercise can be done in any place and at any time and so has a wide applicability for many people. It, therefore, has both psychologic and physiologic effects when practiced."

A program of exercises should accomplish two purposes, according to Dr. McCloy of the State University of Iowa:

"First, the development of strength and endurance, and second, the development of flexibility. As individuals become older, they tend to do much less in the line of physical activity and as a result they deteriorate muscularly and become considerably rigid. The individual soon finds his strength is inadequate for a regular, very active life. An illustration like the following analogy will bring this a little more clearly in focus. Suppose someone were to ask you (for example) during the cold weather of winter, to wear under your clothing, a jacket weighted with lead, let us say of thirty pounds. Your response to the individual would probably be that it would be silly to wear a pack of thirty pounds all day. You would probably be exhausted by noon. If, however, your muscular strength is just adequate to handle a man thirty pounds lighter than you are, but

still be at your present weight, you can see that you would be undermuscled thirty pounds instead of being overweight thirty pounds. This would seem to me to make it clear that an individual needs enough strength and muscular endurance to do his daily work easily without undue fatigue, so that normally he would come to the end of the day sleepy, but not tired. Where the individual lets himself undergo a process of muscular atrophy, he soon gets to this point where he is undermuscled for his weight. This would mean perhaps that the individual should get his exercise regularly, three times a week, which would keep him up to normal. This does not mean that he should be made into the physique of a professional weight lifter or anything like that. He should be normal for his weight.

"Indeed, the other matter is the item of flexibility. As an individual sits a great deal, the fascia surrounding and interpenetrating his muscles becomes shorter. These fascia can readily be stretched by certain types of exercise."

The exercises outlined by Dr. McCloy for the older age group begin when the patient is in bed. The purpose of this is as follows:

"One often wishes to exercise in the morning, it is convenient, he is undressed, and he does not need to go someplace to exercise later in the day or to exercise at night when he is tired before going to bed, when it might also awaken him too much. However, most people upon arising in the morning, feel extremely unwilling to exercise. What has happened is that during the night the blood has collected in the splanchnic area, hence there is less blood out in the general circulation. When the individual gets out of bed, gravity pulls some of this blood out of his brain and he has a temporary brain anemia, with a feeling of no energy.

"By doing the first few exercises in bed he gets the blood squeezed out of the splanchnic area into the general circulation and when he arises to do the other exercises, he feels fine.

"There is another possibility relative to exercise which would be particularly applicable to individuals who have made recovery from coronary occlusion and things like that. A team of German research workers, Hettinger and Muehler, have reported something that is quite remarkable. If an individual puts a tension on muscle that amounts to as much as two-thirds of the maximum that the muscle can lift and does this for six seconds a day, the muscle will increase in strength as much as five per cent per week up to its maximum. The theory behind it is that this effect is brought about by the phenomenon of anoxia brought by this sustained isometric contraction.

"For example, if you will raise your upper arm forward to a right angle and flex your forearms so that the two forearms are in line and place a fist within the other palm, by simply pressing the two hands together hard for six seconds, at the same time breathing normally, you keep the glottis open, you can see that you can put the pectoralis major group on a tension with very little extra trouble. I have seen exercises of this

kind prescribed by a leading cardiologist for an individual who had a coronary occlusion and was still in bed from that occlusion. Obviously, the coronary occlusion was not a very severe one. But the cardiologist checking on the blood pressure and pulse rate of the patient decided that the exercises were well within his powers and would be beneficial."

Dr. McCloy finds that:

"There is no one posture that is suitable for everyone. As the human race has evolved, different people have gone farther away from aboriginal ancestors than others. Numerous people have skeletons, particularly the spine, the head, the feet and the pelvis, that very much resemble the ape. Others, and these constitute the vast majority, might be termed the average human type. A few have gone still farther away from the anthropoid and exhibit what I have called an ultra-human type of posture. This is hard to determine without an x-ray. However, the method of achieving a good posture—good, functionally—is about the same for all. The benefits of such good posture have been made here by Goldthwaite, Brown and others. One of the things that most of them would need would be that since they have achieved the poor posture, (as many of them have) there would need to be a considerable amount of stretching and things of that kind, to get back to what might be a good posture."

From the radio script "The Sitting Man," the ideas of Dr. Laurence Morehouse are further elaborated in the following:

"Many persons can correct their posture appreciably by remembering one of two simple tricks. The first is to level the pelvis; the second is to raise the breast bone. Difficulty with the pelvis arises largely from the fact that we sit down so much. In a sitting position, the body adapts itself to the situation. The body ligaments in the front tend to shorten, while those in the back lengthen to accommodate the greater distance from hip to knee. The long periods of sitting accentuate this stretching. When the individual rises, the ligaments tend to remain long, thus permitting the pelvis to tip forward. The contents of the abdomen spill forward against the front wall, producing the business man's paunch. This potbellied effect can be seen even on people who are otherwise not overweight. In fact, some people who have it try to remove it by reducing when the only thing wrong with them is their posture.

"If you think of the pelvis as a bowl you can see how its contents fall forward when it is tipped toward the front. If you tip the pelvis back to its correct position, you balance the contents of the bowl properly, and they no longer fall forward. The paunch may disappear altogether if you are not overweight. It is actually possible to take two inches off the waist just by making this postural correction.

"At first it may be difficult to get the pelvis back where it belongs. At least it is hard to hold it there because it puts a strain on other muscles and ligaments which are involved. One good way to start is to give

special attention to it while you are walking. Every step helps, and soon it may become a habit. Dr. Morehouse suggests that whenever you have a little walking to do, make a posture walk out of it thus making every step a corrective exercise.

"The second point to remember in posture is to raise the chest slightly—elevate the breast bone and allow the head and shoulders to relax. Bringing the breast bone up half an inch or so is not especially difficult, and it results in a comfortable and easy posture. The shoulders automatically fall into the right position, so they can be forgotten. The neck can be relaxed so that you won't look and feel as stiff as a ramrod.

"These two minor adjustments—the level pelvis and the raised breast bone—not only improve the mechanics of walking and digestion and other bodily processes, but they immediately give the appearance of a more vital and vigorous person. People who have participated in these reconditioning programs have stated that standing erect in this way has really helped them to change their outlook on life and become more positive and optimistic.

"The sedentary person may have become so flabby in muscle strength that opening a jar is something of a feat and opening a difficult window may require a major effort. Perhaps if he has to hurry upstairs, he sees spots before his eyes. If he has to climb to the top of a football stadium, he has to stop a couple times on the way up to rest. Such difficulties are indications that muscles are not accustomed to being used very much and then even the reactions of the blood vessels have grown rusty from disuse. This does not refer, of course, to the symptoms of people with heart disease, but to those who are otherwise healthy but who have lost their stamina because they never make any demands upon it.

"When muscles are not used, they tend to waste away. As the individual notices a decrease in strength, he may respond by protecting himself even more and taking it even easier than before. He uses his body less and less and becomes more and more sedentary. Before long he reaches the point where he doesn't like any kind of physical effort, such as that involved in bowling or dancing or playing golf or even walking.

"The first thing the sedentary person can do is just to decide to be more active. A good way to begin is to start walking more. Instead of driving the car to the nearby grocery or drug store, take a walk—not just a stroll, but a reasonably brisk walk—remembering to hold the pelvis level and the breast bone up. This will not only begin to increase the general muscle tone, but will help blood circulation and other processes of the body.

"After a few weeks, add some further physical activity—bowling, dancing, golfing, or any of the lighter kinds of pleasant exercise. Any activity of this kind helps to reverse the process of deterioration. If you don't care for sports, or if it isn't convenient to engage in them, it is possible to keep in good condition by a regular program of calisthenics. For sedentary people these exercise programs may be as short as ten minutes each.

"Exercise of the neck will frequently prevent the headaches and burning sensations that is complained of in this area.

"Another problem of the sedentary worker is that of

relaxation. You might suppose that anyone sitting down is relaxing, but that is often far from the truth. The sedentary man may be feeling very tense. He may have walked no more than fifty feet during the day and yet find himself unable to relax and go to sleep when he climbs into bed. One technique for releasing this tension is simple but often very effective. As you are lying in bed, tense every muscle in the body and then let go as much as possible. Allow the tension to be released slowly, preferably by a count. When you have released as much as possible continue to count slowly a half a dozen times more, each time trying to relax even more completely.

"Some people are tense because they are breathing unnaturally. In natural breathing, the abdomen moves out as the breath is taken in. Some people develop a habit of chest breathing in which the abdomen moves in as they inhale. Sometimes this results in considerable tension and vague discomfort. Correction of his breathing habits sometimes gives tremendous relief.

"Week-end sports can be dangerous unless they are followed rather faithfully from week to week. If you are used to playing thirty-six holes of golf every week-end, you will stay in fair condition from Saturday to Saturday. But if you haven't played golf for several months it isn't a good idea to try for seventy-two holes on your first week-end on the course. This same thing applies to skiing and other active sports.

"Finally, here is word to the housewives. Housework is exercise, all right, but it isn't enough to keep your body trim. Even the best football player can't keep in condition just by playing the game. He has to exercise between games and he performs other conditioning exercises. The housewife should have some kind of outside exercise which is a little more interesting than scrubbing the floor or vacuuming the rug. Otherwise she becomes fatigued, not only from the housework but from boredom."

Taking just a little different slant on this exercise problem, Dr. Janet A. Wessel of Michigan State University said:

"I do not believe that special exercise prescriptions is the answer. I would rather see individual's activities for the day analyzed to see what can be done to improve his movement patterns through his daily activities. I believe that through such analysis we can make the individual aware of his movements, of how they influence his physical and mental condition. I would use special exercises only when one's movement patterns are limited through trauma, through disease or illness—mental or physical—which incapacitates the individual to such an extent that he needs special consideration.

"I believe that every patient treated in hospital or doctor's office over a period of time should be shown simple postural exercises for sitting, standing and walking. If the nurse is taught the need for keeping the patient in good postural alignment, why shouldn't the patient know what it is all about? These simple exercises for balancing the body in different activities can be

taught by nurse and/or physical therapist. Whenever feasible instruction in balance body positions can be part of the total treatment of the patient. And, the patient should be educated to the value of exercise and physical activity upon the recovery process and the prevention of deconditioning phenomena. If he understands the value of physical movement upon his recovery, maybe he will begin to realize its importance for maintenance of optimal physical condition in everyday life.

"I believe that movement . . . not just prescribed exercise . . . is what is important to life. No one exercise done at specific times in a specific place is the answer. But the examination and analysis of one's total life activities through a typical day and week should be made . . . it may be that changing a simple movement pattern . . . kind, amount, and the way it is done . . . may be sufficient to maintain one's physical potential. Maybe by walking a little more than usual, by developing a hobby that demands physical activity appropriate for the physical level of the individual is the answer. Only when one's work and play cannot maintain the physical potential of the individual would I suggest the 'flat on the back approach to physical fitness' . . . prescribed EXERCISE."

In order to elaborate more fully on Dr. McCloy's reference to the work of Hettinger and Muehler, we asked Dr. H. Montoye to summarize their article which appeared in *Arbeitsphysiologie* 15:111-116 (1953), entitled, "Muskelleistung und Muskeltraining". The summary follows:

"Seventy-one separate experiments performed on nine male subjects over a period of eighteen months provided data on how the development of strength in a muscle was related to the intensity and frequency of training activities. All training was in the form of static contraction held for a measured length of time against a spring scale, and most of the observations were made on the flexors and extensors of the forearm held horizontally at right angles to the upper arm. On Saturdays maximal strength was measured. The higher reading of two trials was recorded. Sunday was a day of rest. Mondays through Fridays were spent in training sessions in which the intensity of contraction, the amount of time held, and the number of practices per day were varied. The study revealed the following findings:

1. Muscle strength increases an average of 5 per cent per week when the training load is as little as one-third, or even less, of maximal strength.
2. Muscle strength increases more rapidly with increasing intensity of training load up to about two-thirds of maximal strength. Beyond this, increase in training load has no further effect.
3. One practice period per day in which the tension was held for six seconds resulted in as much increase in strength as longer periods (up to full exhaustion in 45 seconds) and more frequent practices (up to seven per day).

4. The cause of the increase in strength (training stimulus) they believe is neither the intensity of contraction nor the degree of exhaustion of a muscle fiber, but rather a condition in which the oxygen supply to a muscle fiber ceases to be enough for its needs. A further oxygen deficit is not a stronger or more effective stimulus. This, they postulate, is an "all or none" characteristic of the "training stimulus" or stimulus to hypertrophy. The observation that strength grows more rapidly as the training load increases from about one-third to two-thirds maximal strength is to them only an apparent contradiction. They believe that due to the internal arrangement of fibers within a muscle not all fibers are equally taxed, so that not until the training load is about two-thirds maximum are all fibers suffering some oxygen deficit.
5. From measurements of biceps diameters in maximal contraction they calculate a maximal contraction strength of 6.6 kg/cm₂ (about 95 pounds per square inch) of muscle cross section. They found that the calculated muscle cross section increased in accord with this factor as strength increased. Thus, they conclude that the effective training stimulus extends from somewhere below 2 kgs. to somewhere under 4 kgs. per square cm. of cross section.
6. They found a correlation of $+0.77 \pm 0.09$ between (a) maximal increase in strength due to training and (b) the speed of this improvement, when twenty different muscle groups were compared. Finger muscles increased maximally 33 per cent and showed an increase of 3.2 per cent per week. For hip flexors the corresponding figures were (a) 177 per cent and (b) 22.1 per cent.
7. When tension per square cm. of cross section is held constant, endurance (holding time) is unchanged with increase in total strength. This is attributed to improvement in capillarization paralleling hypertrophy.
8. The rate of increase in strength sometimes varied considerably in the same period when two comparable training periods, separated by a long rest period, were compared.
9. There is a ceiling on the development of strength in every muscle. This is usually accompanied by pain resulting from some injury within the muscle that stops further increase in effort.
10. They postulate that the maximal strength of any muscle in the body is probably about three times the tension demanded of it in everyday activities."

Dr. M. S. D. Michael of Santa Barbara College, University of California, quotes a number of authorities to indicate that physical activity has a beneficial effect on the autonomic nervous system in relation to the rest of the body.

"Richter reports that the wild rat has large adrenals compared with the domestic rat and that surgical

trauma along with ACTH has little influence upon the ascorbic acid content, indicating maximum stimulation. When the adrenals were removed, the wild rat died more easily than the domestic, as if the active animal were more dependent on the adrenals.

"Hoagland, in reporting on the 17-ketosteroids as a measure of adrenal response, points out that the higher skilled and less fatigued men have less adrenal activity. The production of the 17-ketosteroids declines with age in this study and also with fatigue during the afternoon. It seems that the more active and less fatigued have better adrenal functioning.

"Van Lier in 1954 was one of the first to find a direct relationship between physical training and the autonomic nervous system. He showed that exercised rats had increased propulsive motility of the small intestine compared to nonexercised rats. The possible explanation was a dominance of the parasympathetic system.

"Taylor reports that forced bed rest has been found to reduce the body to a dangerous state similar to starvation. It is possible, then, that we have a means of strengthening the adaptive mechanism of the body. Exercise might well be a pleasant means of increasing the survival potential in a mechanical, emotional age.

"Persky discusses the difference between physical activity and psychologic (emotional) stress in pointing out that blood eosinophil and glutathione levels are affected only by psychologic stress. Thus exercise can affect the adaptive mechanism without itself increasing the reaction caused by emotions. The advantage of exercise lies in the fact that it stimulates the defense mechanism, not that it is similar to other stresses.

"Exercise in itself is a form of stress and can cause fatigue along with breakdown if not done under controlled conditions. For this reason, the following precautions should be noted:

1. Exercise should be strenuous enough to stimulate, but not completely fatigue the body.
2. The exercise should be spaced so that rest periods follow the activity.
3. The exercise should be regulated to the individual's genetic makeup.
4. The exercise should involve the entire body, not specific areas only; i.e., endurance, strength, agility and flexibility.
5. The exercise should be altered to prevent boredom and maladjustment.
6. The exercise should be continuous throughout life, particularly in middle and old age, when society places greater demands upon the emotions.

Physical activity under these circumstances appears to serve a two-fold function:

1. During an emotional stress, exercise would tend to relieve the tensions built up by the body, preparing for action.
2. Repeated amounts of exercise might elicit the adaptive mechanism which keeps the internal environment in balance and thus improves the ability to adjust stress."

Dr. Leon W. McCraw of the University of Texas says:

"In my opinion the value of physical activity in preventing deterioration is conditioned both by the extent to which an individual has developed prior to maturity and by the degree to which he continues vigorous physical activity during adulthood. This latter is perhaps of more importance particularly in view of the fact that very few people continue to engage in physical activity after reaching maturity. This belief is substantiated somewhat by the research that suggests that there are no differences in longevity between so-called athletes and nonathletes, except where the athletes continue to engage in physical activity.

"To insure the attainment of maximum value from physical activity we must make rather drastic changes in our present day programs. First, we must include in the programs activities that will develop fitness. The sports, rhythms, and more sedentary games that we have for the most part today will not do so. Perhaps we must return to some of the more formalized activities. The football coach does not rely on playing the game alone to condition his squad. Second, we must give our students activities in which they can and will participate in later life in order to keep fit. By this I am not advocating such recreational activities as tennis, golf and bowling. These are good and should receive attention, but we must realize that we can never hope to provide sufficient facilities and equipment to insure regular participation by even one-fourth of our people in such activity. What we need are more activities in which people can engage at home and in the immediate neighborhood. Third, we must install in each individual a desire to maintain good physical condition. This is perhaps the key to our problem. I know many persons in my own profession who do not engage regularly in physical activity, even though they are fully aware of the value of so doing. They just do not have the desire to stay fit. How to develop this desire is something that our profession must solve if physical activity is to have maximum value, particularly in later life."

Dr. Ernst Jokl, now of the University of Kentucky, in an article written for the Springer Publishers of Heidelberg, Germany, entitled, "Alter und Leistung" (Age and Efficiency), stated:

"The first result of this research is that the lifelong physical exercise program which the subjects had followed: namely, apparatus, gymnastics, plus light games and some track and field training, not only developed high standards of physical efficiency, but also maintained them in middle and old age. The evidence proved that a well trained gymnast of seventy is likely to be superior in respect to almost all acquired motor activities to an untrained man of twenty.

"The gymnasts on whom this study was conducted comprised an age group which, according to morbidity and mortality statistics for the general population, would be expected to be affected more than the younger age

group by degenerative diseases of the cardiovascular system, by neoplastic growth, and by kidney ailments. The absence of the disabling sequelae of these conditions among the gymnasts is noteworthy. In addition to the favorable standards of efficiency and health, there was in evidence a remarkably high level of physique and strength.

"These findings raise the following question: Does the lifelong physical training exert a powerful influence that inhibits the aging process on a broad physiologic front, including the decline of physique, the decline of efficiency, and the decline of health? Jokl answers the question in the affirmative.

"Data reviewed would indicate that the rapid increase of longevity which is embraced in Europe and the United States during the past fifty years or so has been accompanied by a general lengthening of the period of optimal usefulness of men and women.

"The process of maintaining resources or even of unfolding new resources of physical strength after age forty, fifty, sixty or seventy is still going on; i.e., the period of fitness lengthens continually. Impressive performances are indicated which indicate the validity of this statement for feats of endurance and skill. Performance records from the German Gymnastic Festival for the Old in Cologne in 1928 were compared with the 1952 results for identical age groups in Marburg. In spite of the misery of the war, a categorical improvement in performance has taken place between 1928 and 1952 corresponding to a collective retardation of aging by an equivalent of six to ten years.

"The following figures indicate the magnitude of the problem under review for this country. Between 1944 and 1952, medical research and improved medical education and rehabilitation have reduced the death from all causes by 9.4 per cent. Five years have been added to the average life expectancy. As a result of these and other advances, the lives of 845,014 Americans have been saved in the last eight years. They earned an added \$1,488,000 to the national income and excise tax receipts. A corresponding and even greater material advancement can be achieved by prolonging the fitness of the aging population, enabling them to continue working and postponing the period of dependence upon family or public support. Indeed, a new, unexpected and fascinating task presents itself to the profession.

"We, therefore, have to continue the battle not only against illness, but also against premature inroads made by aging. That judiciously applied physical training can inhibit aging by many years and that the material welfare of the nation and the happiness of the people can thus be enhanced is shown by this research publication."

Dr. Jokl concludes another paper on the psychology of exercise by the following paragraph which is worthy of quotation:

"Decelerative influence of exercise upon the aging process would be inexplicable without consideration of psychologic incentives. Great musicians who continue

performing in their seventh and eighth decades, like Toscanini, Bruno Walter and Moritz Rosenthal; the famous mountaineers who climbed the Tibetan peaks simply because they were there; the Marburg gymnasts who preserved their fitness well into the second half of life; they all were inspired by mental concepts, by human attachments, by social relationships and, at times, by spiritual convictions. Between the hammer of dynamic ideas and the anvil of a favorable environment, exercise forges and maintains their zest for life."

The thoughts of Leonard A. Larson, Chairman of the Department of Physical Education, Health and Recreation at the New York University School of Education, are summarized very well in the following quotation:

"I believe that one of the major needs that old people have is the absence of physical exercise. So many have the idea that normal movement during their working day is sufficient to meet their physical needs. Another misconception is that long periods of time are necessary in order to achieve a state of condition that will serve a person through the day without reaching a fatigue point early in the day. After doing some personal research and experimentation over the last two years, I am more convinced now than ever that the 'key' concept of maintaining good condition is the term **CONSISTENCY**, not duration or intensity, although movements must be intense in order to achieve and maintain good physical development. I believe that one of our major problems to solve is one of finding content of a fifteen minute to one-half-hour-period during the day for physical activity that will yield an overall conditioning of the body. If the exercises are beyond the normal requirements of the day, and continue every day, the human body will develop beyond the normal demand of the exercise, due to the accumulative effects of conditioning. I sincerely believe that, if we could find some way of encouraging persons to maintain a good exercise program, one's vitality and energy could be maintained for a longer period of time than is now the case. I am also convinced that the stresses and strains that man must go through in a hurried life are highly related to the physical organism in this state of condition. I have also been interested in the therapeutic effects of exercise and am becoming rather convinced of the high relationship that exists between exercise and the state of health of an individual.

"It seems to me that your Society would do well to devote the major part of your work to the problem of exercise at all ages. For example, there are some that believe that the Little League activities are dangerous to young children because of the physical demand. I do not believe that physical exercise during the youthful period is truly detrimental; in fact, hard exercise is desirable. However, we do need the facts and do need to have some experimental research programs to gain necessary information."

The following summary of the discussions on physical education and exercise represents a col-

laboration on the part of Dr. Janet A. Wessel and Dr. Frederick C. Swartz:

All opinion sampled testifies to the benefit of physical education and physical exercise in the preservation of health in the aging group. Moreover, it is definitely indicated that the so-called physical stigmata of aging might be postponed a number of years by the institution of planned physical education and exercise.

As worthy as these ideas may be, the sales resistance encountered is great when the plan takes fifteen to thirty minutes out of each day, or even this amount of time three days out of each week. Education as to the continual need of physical exercise for good health and the prevention of disease may reduce this resistance to a degree. Each teacher, each physical education major, each coach of the various sports, each dancing or swimming instructor, as well as the members of this auxiliary department to medicine and the medical doctors, must by precept and example attempt to further this education.

Patterns of exercise beginning in bed and continuing into the "up" position certainly have much to recommend them, if the patient will just do the exercises.

In an effort to eliminate the "set-aside" time period, another concept was suggested. The needed physical exercise or "movements" would be woven into the pattern of everyday living so that by minor modifications of routine activity the objectives of the physical exercise could be accomplished. This program, enforced by an appeal to grace, beauty, glamor, physical stamina, and the prevention of pain and physical tension, might be more productive than our previous efforts have been. These patterns of exercise incorporated within the scheme of daily activities set the design for efficient movement of all parts of the body, so that in sitting, standing, lying, walking, running, pushing, pulling, lifting, or carrying, a maximum of work is accomplished by a minimum of expenditure of effort.

Logically, it follows that if physical exercise possesses the potential of improving health and prolonging the life of the average man, might it not do a better job by studying in addition, our usual methods of locomotion, sitting and resting to the end that these might be done with better mechanical advantage and therefore less expenditure of energy?

This study indicates rather definitely that many of the so-called stigmata of aging are the result of poor care of the machine God gave us. This is really not, therefore, a problem of aging, but one of youth, and it is at this level or younger that the effort and emphasis must be laid.

Dr. Janet A. Wessel's words seem to fit here particularly well:

"Regardless of where your work takes place—the home, factory, office, classroom, athletic field, or drawing room,

"Regardless of whether your play takes place on the dance floor, bridge table, on water, land or in the air,

"Regardless of how or what form of rest you have spacing your activities—

"You are shaping or reshaping yourself every single second of your life. Your shape and the running order of your body are being molded on a twenty-four shift—not during ten minutes a day of specific exercise, or in a weekend of sports and dances, nor even in outdoor gardening activities or in daily housework, BUT IN ALL THESE ACTIVITIES AND MANY MORE."

In the section of nutrition of the article on "Preventive Geriatrics" in THE JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY of May, 1954, Dr. Arthur H. Smith says:

"One cardinal fact stands out; namely, that the aged malnourished patient is reaping the harvest of his yesteryears. The results of poor nutrition are more often than not insidious in their operation, and so by time old age has arrived there may have been established functional and even structural lesions which are the consequence of poor dietary habits begun years ago."

Dr. Edward F. Crippen, a member of the Committee, adds here:

"I suppose there will be a day, we shall diet all our life. I wonder if it is worth it when we know that it doesn't make much difference in a head-on collision whether we had French-fried or boiled potatoes for supper, but in case we make it to age sixty-five, I think the old adage as applied to appearance is similar; i.e., 'what we look like up to age fifty depends upon what our parents looked like, but after fifty depends upon what we did before fifty.' A major problem in the nutrition of the aged has been introduced by the cryptic remark, 'many oldsters would eat properly if they would eat.'"

Dr. Charles Sellers, also a member of the Committee says:

"A high percentage of aged persons presents some primary nutritional disturbance that is so insidious in its development as to go unnoticed for a long time. Generally, it revolves around a high carbohydrate and low protein and vitamin intake. It results in a lessening of physical strength and, hence, activity, loss of ability to concentrate, and some behavioral problems.

"Both overnutrition and undernutrition occur in the aged and come about through long established, faulty dietary habits. These habits become rigid and difficult to overcome, because the psychologic pattern and sociologic implications are deeply rooted. An approach to optimum weight from either inanition or obesity with a well balanced diet containing adequate, but not excessive carbohydrate, protein and vitamin content, would be a step toward better health in the aged."

Dr. Hazen A. Price then broadened the discussion by saying:

"Whenever the nutritional status of people past fifty years of age is being discussed, it should be pointed

out that it has yet to be proved that the nutritional requirements for optimum health are much different in the older person than in the other age group. It should also be remembered that there is a great variation among older people in their apparent need for the usual basic elements. Some have adapted themselves over the years to an intake of the various essentials consistently below the optimum level, either through ignorance, for economic reasons, or simply because of the lessened demand through relative inactivity and yet they seem to remain in a reasonably good state of health.

"In general, it can be said that as life becomes more sedentary, decreasing thereby the rate of body metabolism, the total caloric need is appreciably lessened. With this decrease in energy requirement, the demand for carbohydrate and fat in the diet is thereby much less. Protein breakdown is also decreased, but to a lesser degree, for it has been shown that a larger percentage of protein is required in the older person to maintain a positive nitrogen balance than in the younger individual. Some investigators have shown that a state of nutritional health can be maintained on as little as 43 grams of protein daily, while others, who are in the majority, feel that 65 to 80 grams are necessary.

"When the total caloric intake is too low, the protein storehouse in the body may be seriously depleted in an effort to make up the deficit. It is essential, therefore, that the total number of calories be sufficiently large to protect against this breakdown and this is best done by carbohydrate and only a minimum amount of fat for palatability.

"Fatty foods, particularly the fried variety, are not well handled by the older person's gastrointestinal tract often times creating digestive disturbances with secondary ill effects. Then, those persons with a familial disturbance of lipoid metabolism tend to develop coronary sclerosis, in particular, much more often than other persons. The role of dietary fat in the production of arteriosclerosis stands out as a significant factor, and the evidence of this is becoming more and more substantiated.

"Mineral requirements in the aged are likewise substantially the same as in the young adult. Frequently, the optimum amounts of the diet are not maintained because of the general low intake of milk and vegetables by the older person. The need for calcium should require no emphasis, when osteoporosis is so common later in life. Iron is seldom a major deficiency, provided there is no blood loss, for the iron storehouses are usually adequate to supply all the marrow needs.

"Vitamin deficiencies are not nearly so common as one might suppose and the need again is no greater than for the younger adult. Because of the tendency to assume carbohydrate more than other foods, a lack of the 'B' factors is most often observed. Wilder has shown that when vitamin B is lacking to a significant degree in the diet, patients become more forgetful, irritable, apathetic, confused and depressed. He found, too, that mental changes, mainly apathy and those of personality, resulted from prolonged protein deficiency. Brozek, in extensive control studies at the University of Minnesota, showed that B complex deficiencies gen-

(Turn to Page 603)

Meat...

Good Nutrition and the

Metabolic Changes of Adolescence

The sharp increase in nutritional requirements during adolescence is ascribed to the rapid growth, restless activity, high basal metabolism, and increased rate of organ development during this period.^{1, 2} Nutrient needs during adolescence are higher than at any other period of life³ except for pregnancy and lactation.

In order to satisfy these extremely high nutritional requirements, "protective" foods supplying liberal amounts of protein, vitamins, and minerals should predominate in adolescent diets.³ Such foods include meat, poultry, fish, milk, eggs, vegetables and fruits, and whole-grain or enriched cereals and enriched bread. Accessory foods commonly eaten by adolescents to satisfy emotional needs may provide energy, but are commonly responsible for obesity and should not take the place of the "protective" foods.

Meat contributes much toward making the daily meals of adolescents appetizing, ample, and satisfying as well as adequate in protein, B vitamins, iron, phosphorus, potassium, and magnesium. Its complete protein functions in all physiologic mechanisms utilizing protein—tissue growth and replacement, fabrication of enzymes, hormones, and antibodies, and maintenance of the body's fluid balance. Its B vitamins and minerals take part in many processes of intermediate metabolism important in body development.

1. Toverud, K. U.; Stearns, G., and Macy, I. G.: *Maternal Nutrition and Child Health. An Interpretative Review*, Washington, D.C., National Research Council, National Academy of Sciences, Bull. No. 123, 1950, p. 115.
2. Proudfit, F. T., and Robinson, C. H.: *Nutrition and Diet Therapy*, ed. 11, New York, The Macmillan Company, 1955, p. 271.
3. Martin, E. A.: *Roberts' Nutrition Work with Children*, Chicago, The University of Chicago Press, 1954, pp. 231-236.

The nutritional statements made in this advertisement have been reviewed by the Council on Foods and Nutrition of the American Medical Association and found consistent with current authoritative medical opinion.

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(Continued from Page 602)

erated general weakness, incoordination and neuromuscular deterioration. He also found that prolonged dietary deficiencies are apt to affect man's willingness and capacity for work. Changes in personality make-up were sufficiently altered so that motivation, a crucial factor in all achievement, is readily affected.

"As in all types of medical practice, prevention of illness is usually easier than correction of the condition after it is fully developed. So, in nutritional disorders, the establishment of proper eating habits in the young adult will prevent most often the serious consequences of long continued undernutrition. Overweight plays a large part in the disabilities of older people and is a serious drawback in programs of rehabilitation. Patterns of eating which have been practiced for decades are not easily broken, and when attempts to change them are made, frustration may follow. In a recent study it was shown that with proper diet, great improvement occurred in attitudes, physical tolerance, behavior and cerebral acuity. All of this resulted in a far greater self-sufficiency in practically all of those studied, except, of course, those with irreversible psychiatric or insurmountable social problems."

Dr. C. Howard Ross, Committee member, says:

"The state of nutrition in the aged varies from very excellent to very wretched. The wretched state seems to enter when lonesomeness and worthlessness are experienced. It has been shown that old people, living alone, may easily drift into a 25 per cent deficient diet, without being particularly aware of the departure. One of the greatest problems of the family physician is to impress upon the newly-created widow or widower that there are nutritional factors to be faced. It is his responsibility to outline one or more physical programs, and nominate the diet regimen which would match the activities suggested."

The status of fact in the problem of nutrition is further emphasized by Dr. Lawrence Rarick from the University of Wisconsin when he states:

"Increase in body fat is a characteristic of aging. While the age-associated increase in fat may be associated with a decrease in hormonal output, the accumulation of fat is usually accompanied by a decline in the energy output. For example, Brozek at the University of Minnesota compared a group of physically active males with a group of physically inactive males drawn from a large population of healthy, middle-aged business and professional men, and found that, although the weights of the two groups did not differ materially, the estimated content of fat in the inactive group was substantially higher than in the active group. In many primitive cultures, where the demand for survival requires much in the way of physical activity, the problem of obesity is not so evident. Studies on the physical characteristics of the Yami Tribe living in a small island south of Formosa, isolated from the influence of mode in civilization, have shown that after twenty-five years of age increases in weight are negligible.

"From the data now available, it appears that the accumulation of body fat is more marked during the third and fourth decades of life. It has also been shown to be the period when the human normally assumes a life of relative physical inactivity. Furthermore, the process of aging brings on a notable change in the chemical composition of body fat. The soft fat of youth tends to be replaced by a higher proportion of 'hard' fat, with its higher proportion of saturated fatty acids which Keyes and others believe to be a prominent factor in bringing on the cardiac involvements of aging. Repeated observations on animals given an ample exercise throughout the life span have shown that the exercised animals possess relatively more muscle tissue and less body fat than do unexercised animals.

"The studies at Harvard University show that the problem of obesity begins early in life and is not so much a matter of excessive food intake as of under activity. The observations disclosed that the dietary habits of the overweight children were not materially different from the normal children, but the overweight children were extraordinarily inactive. This pattern of physical inactivity tends to persist and cannot be ignored as a possible factor in contributing early fat accumulation with concomitant symptoms of aging. As Mayer has pointed out, 'the combination of physical sluggishness, a high fat diet, and high caloric diet, and the highest cigarette consumption in the world, may well be the deadly combination which prevents half of thirty-five-year-old Americans from reaching 'three score and ten.'"

Dr. R. E. Austin, Committee member, writes:

"It would seem that any discussion of the maintenance of an adequate physical machine to insure comfort and longevity in our aging population must of necessity consider adequate nutritional intake, both in the formative years and in those of the so-called declining years. The intake of adequate quantities of essential foods must depend on the general interest of the individual in his environment and his being in pleasant surroundings with sufficient activity to stimulate an appetite.

"During childhood and most of our adult years, the problem of being able to ingest a balanced diet to assure good protein, vegetable, and vitamin intake does not present much difficulty; but, as our teeth become carious and absent, our ability to masticate meat, vegetables with fiber and vitamin content, and a variety of solid food decreases. This must result in decreased protein intake so necessary for normal anabolic processes in the body, and decreased opportunities for gainful employment which make an individual feel essential to society, further inhibit his desire and ability to ingest adequate quantities of food.

"What may we do that will prevent or delay the onset of nutritional deficiencies in our aging population? First, of course, comes maintaining busy hands and minds for our senior citizens, and making them feel useful and needed in society. Second, a program beginning in childhood and continuing throughout the remainder of our lives in preventing dental caries

and availing ourselves of good dental care (fluoride, adequate dental consultations, et cetera). Third, supplementation of diets of the older age groups with sufficient quantities of vitamins to insure adequate intake despite changes in eating habits. Fourth, inclusion in our diet of goodly amounts of proteins in the form of meat or meat substitutes especially designed for the increasing proportion of our elder citizens."

Dr. E. W. McHenry, Professor of Nutrition, University of Toronto, writes:

"My impression of nutritional conditions among older people in this area is that, generally, conditions are not good. They are particularly bad for older people living alone. They are better in the case of institutionalized persons. Senile persons in institutions have been studied and they can be divided into two groups: those who eat sparingly and the gluttons. The latter group overeats, especially bread. I think it is worth while to ensure that older people are nourished adequately. An improvement in health is difficult to prove. At least, it is possible to prevent digestive upsets with properly planned meals.

"The main factors influencing the nutritional state of older persons are:

1. The adherence to long standing food habits and even the return to the habits and the foods of childhood.
2. Economic circumstances, particularly with people living alone.
3. Poorly fitting dentures, or the lack of use of dentures.
4. In the case of older persons living alone, the lack of cooking facilities and the absence of incentive to prepare and eat meals.

"Various types of corrected measures can be used:

1. The provision of one hot meal a day in a center to which older people can come for the meal and companionship.
2. Good meal planning and good cooking in institutions for the elderly.
3. Educational efforts supplied by physicians and nurses. The best time to ensure adequate nutrition for elderly people is in childhood, when food habits are being formed.

"There has been a suggestion that an adequate intake of nicotinic acid will prevent the onset of senility. There is no evidence that the administration of the vitamin will ameliorate senility. This question needs further study.

"In my opinion, the mental attitude expressed ensures good nutrition; namely, willingness to try new foods (or experiences) and the absence of rigidity in outlook also helps to delay senility. An interest in new things is highly beneficial both in nutrition and generally."

Dr. L. B. Pett, Chief, Nutrition Division, Department of National Health and Welfare of Canada, contributes the following:

"It is frequently stated that many of the aches and pains, weaknesses, and difficulties associated with growing old could be avoided by better nutrition. Specific advice on how to do this is still difficult, since most of the evidence is inferred rather than established. A few things may be said:

1. A balanced diet throughout life appears to do more good than any kind of diet or dietary supplement begun in later years; so start early.
2. Nothing in excess. This aphorism of the Greek philosopher, Solon, needs to be followed throughout life. It applies to individual food constituents, such as fats or vitamins, as well as the foods themselves. It is a nutritional signpost on the road to health, but it needs to be balanced by an idea that was not stated by the Greeks; namely, keep up in your older years a little of everything that you have found to suit you.
3. Eating a variety of foods is certainly the "keynote" of good nutrition. Continuing to eat a variety of foods requires conscious effort in old age, when loss of teeth, economic stress, loss of appetite, gastric upsets, illnesses and various diseases, work to produce poor eating habits and ultimate malnutrition.
4. Keeping up physical activity, perhaps of a different kind, but still enough to flex muscles and improve the circulation, is just as important as the diet in avoiding some aspects of senescence. It will help muscle tone and stimulate appetite and interest in life, just as eating a variety of foods and keeping up some physical activities becomes increasingly difficult and requires continuous thought and effort.
5. Since the amount of food must be balanced against the amount of activity, and since illness and laziness tend to reduce the amount of activity in old age, it follows that the foods eaten must provide more and more essential nutrients and less and less volume and with fewer calories. To do this, the empty calories represented by sugar or fat must be decreased.
6. Some protein of good quality should be eaten at every meal. The best and cheapest of such protein comes in milk, cheese or eggs and meats like liver.
7. If the above advice is being followed, weight control will be achieved at all ages, food habits will avoid excesses, mental activity and outlook can be maintained at a suitable level and nutrition will be making a real contribution toward prevention or postponement of the diseases associated with the aging group."

Dr. Icie G. Macy, Consultant, Merrill Palmer School, opined that "optimal geriatric nutrition" was "today's challenge," and in support of this idea offered the following:

"The ultimate goal of the science of nutrition is to establish a standard of dietary intake that will provide for the highest obtainable level of health and well-being for every human being regardless of age, race, religion, political belief, or economic or social condition.

PREVENTIVE GERIATRICS

Optimal nutrition and an adequate diet are recognized as the prime factors in the propagation of individuals with the maximum potential for physical development and maintenance of physical and mental health throughout life.

"Our concepts of the composition and role of foods have changed with the rapid development of medicine and the science of nutrition. Recent times have been rich in discoveries which have led to the evaluation of different foods on the basis of their chemical and biologic properties. In addition to the 'proximate principles'—proteins, fats, carbohydrates, and minerals—today more than fifty nutrients obtained from foodstuffs are known to be present in the body and to be necessary for life and health in varying quantities ranging from macro to micro amounts. A recent publication quantitates milk—Nature's most nearly perfect food—in terms of more than 250 different constituents! We have reason to believe that other common foods will be found to contain a similar abundance of individual nutrients when they have been studied more completely. Physicians and scientific investigators in many fields respect more than ever before the role of dietary relationships and imbalances among the essential nutrients in the diet in relation to health.

"The demonstrated importance of nutrition to the health of population groups everywhere placed modern evaluations of food on a *cost per nutrient basis*. Although we still lack complete knowledge of the composition of common foods in use in the countries of the world, the United Nations' economic policies with regard to food supply are now being formulated not so much in terms of dollars and cents as in terms of the physiologic needs of man. World food supplies and nutritional 'targets' now are considered in terms of a balanced diet, with food, agriculture, and nutrition as basic factors in international relations.

"*Optimal health and optimal nutrition* encompass broad and more positive attributes, such as stamina, efficiency, reserve, and capacity. Indeed, the World Health Organization, with its primary object the highest possible level of health for all people, has stated in its constitution, "health is a state of complete physical, mental, and social well-being, and not merely absence of disease or infirmity." Advances in medicine and science, including nutrition, aided by a better flow of scientific information to the public, have already contributed to a longer span of life. Therefore, today's challenge is to make these later years abundant ones and to enable aged men and women to enjoy the fruits of their labors and at the same time maintain their independence, dignity, and a useful role in society.

"Research has demonstrated the chemical as well as the physical individuality of people at all ages; hence a new branch of science has come into being—chemical anthropology. Studies of life processes also have revealed the dynamic nature of the body. These studies show that nutrition is truly food in action and is the *chemistry of life*, as Professor Lafayette B. Mendel so aptly proposed more than three decades ago. Much research remains to be done, however, on the aging processes and their effect on the utilization of the diet

and metabolism, and on the dietary requirements of older people.

"As we grow older, we accumulate the results of accidents, infections, malnutrition, and other untoward conditions, and these scars of living may be carried over from one epoch of life to succeeding ones and thereby warp or dwarf the later years. Although these scars acquired in the adventure of life may not be obvious and disabling in themselves, they can weaken the structures and functions of the body to the extent that, when acute illness, accident, or shock occurs, prolonged disability and chronic illness may result. Every individual has a characteristic capacity to utilize and store chemical elements from ingested foodstuffs, a capacity determined by heredity, eating and elimination habits, and physical and mental states. A diet for an old person should therefore be based on a knowledge of his dietary history as well as other factors pertinent to establishing optimal geriatric nutrition. As Hippocrates (460-370 B.C.) recognized long ago, 'a slender and restricted diet is always dangerous in chronic disease and in acute disease where it is not requisite. And again, a diet brought to the extreme is always dangerous.'

"In the aged, long standing and persistent bad food habits are not easily changed, especially in those of low economic status and in the disinterested groups. Chronic misfeeding, which may date from birth, frequently results in the body's becoming 'conditioned' to a poor diet. The results are evidenced by poor nutritional status. There is no doubt that poor nutrition over extended periods of childhood produces an adult of inferior physique, less stamina, and the prospect of premature aging. Food must nourish the body under all types of conditions and circumstances.

"It is frequently assumed that the dietary patterns of old people, especially those living alone, are molded primarily by such factors as economics and the condition of the teeth. Evidence accumulated from several recent surveys, in this country and in England, of customary food habits of persons of sixty-five years or older, shows that these two factors are not necessarily the most important. These subjects were not restricted in their choice of food; 67 per cent were moderately active, with the remainder sedentary.

"The results show that more than half of the individuals did not consume enough yellow and leafy vegetables to provide the vitamin intake recommended by the Dietary Allowances of the Food and Nutrition Board of the National Research Council. Similarly, citrus fruits and other foods high in ascorbic acid were inadequate in 40 per cent of the diets. Forty-three per cent showed an intake of less than one pint of milk or its equivalent in cheese per day. There is good evidence that poor vision in the dark and eye strain in bright light may have some relation to the diet of the aged. Low consumption of milk and of vitamins A, C, and D can contribute to poor calcification and fragility of bones, and to slower healing of bones and delayed recuperation of nerves after shock, injury, or other traumatic experience. A person who has little physical reserve or stamina, owing to cumulative scars

from injury or disease and depletions during life, needs an individualized diet prescribed by a physician who knows the patient's dietary history and nutritive status, as well as the presence of any disease.

"In the surveys of old people, medical and social factors were more frequent than economic reasons for changes in eating habits with advancing age. Laxatives were taken routinely by 55 per cent, varying from three times a month to once or more daily. The laxative habit alone may reduce the body's ability to absorb and retain fat-soluble vitamins already in low supply. The consumption of starches and sweets was less than what one is frequently led to expect. For men and women the average caloric intake decreased with age, probably as a result of a tapering-off of activity. With deterioration of health there was a reduction in consumption of meat products and green vegetables.

"An adequate intake of a balanced diet is thus the first requisite for obtaining optimal geriatric nutrition. The body requires the proper proportion of foods that contain proteins of high quality and minerals for the upkeep of the body tissues and bones; foods that supply adequate amounts of each of the vitamins so essential for regulating and supplementing proteins and minerals in metabolism of all the tissues of the body; and food that supplies energy. Inasmuch as investigations of dietary habits of elderly people show a voluntary tendency to reduce their consumption of the first two classes of foods (proteins, minerals and vitamins) that are most essential for body preservation and restoration, it is important to place greater emphasis on the inclusion in the diet of more generous portions of milk, meat, green and leafy vegetables, and citrus fruits or other vitamin C-containing foods. Caloric intake must be made adequate for individuals with depressed appetites, and restricted for those who tend to become obese.

"Our knowledge of the physiologic processes of aging is incomplete. Life histories are difficult to obtain with a reasonable degree of certainty and accuracy. And our knowledge of essential nutrients in common use, and the extent to which the concentrations are influenced by modern practices in agriculture, food preservation, and service, is limited. These are only a few of the areas of inadequate information that prevent efficient and effective application of the knowledge we already possess. No effort should be spared in learning how to care for our ever-increasing numbers of older people so that they may continue to play an active and beneficial role in society and not become an added burden to younger generations."

The impression of C. G. King, Executive Director of the Nutrition Foundation, Inc. of New York, is as follows:

"Persons in the older age group show most of the dietary flaws characteristic of our general public, but in greater degree. Many are overweight, especially in view of their age, usually show a lesser development of muscularity and lessened scheduled physical activity. There is undoubtedly some undernutrition occasioned

in part by low economic levels, a general debility, less incentive to prepare and enjoy their meals, and often a degree of despondency or loneliness occasioned by their social environment. Malnutrition in the severe form is only an occasional problem, but there is a reasonable amount of nutritional anemia, constipation, and mild scurvy caused by low intake of fresh and carefully prepared fruits and vegetables. There is considerable doubt whether the incidence of osteoporosis presents a true malnutrition that might be related to low intake of calcium, protein, Vitamin 'D' or other specific nutrients and poor dental conditions.

"I believe the primary need for improving the nutritive conditions for older members of the public could be met by more careful education of the administrative officers in charge of institutions for the aged and also a program to reach individual homes in which older people reside. I do not think that the basic problem is often economic, although undoubtedly that aspect of the problem is sometimes serious.

"Convenience and socially favorable living conditions are important both psychologically and for the good morale that is important in meeting most of their problems, including nutrition. Most institutions, whether for the aged, or otherwise, develop a horrible degree of lethargy in the preparation and serving of foods. Of course, this situation prevails in other respects as well, but I think it may be worse in respect to food practices than in other areas of responsibility.

"Prevention of premature aging processes can be importantly effected by good nutrition practices beginning with gestation in infancy. For example, dental deficiencies apparently are established chiefly in the very early years, and it appears that the development of atherosclerosis, liver disease, diabetes, (possibly cancer) and other metabolic conditions that afflict old age severely, may be influenced by poor nutrition practices in early years.

"There is little doubt that maintenance of ideal body weight, prevention of dental cavities, and an early adoption of good nutrition practices would markedly defer the aging process. With respect to specific nutrition practices, it appears that a consistent intake of good quality protein foods, such as meat, fish, eggs and milk, fruits and vegetables, whole or enriched cereals, and a sufficient caloric intake to maintain the body weight near the ideal would represent type of nutrition practice that would afford substantial protection.

"An educational program beginning with the pre-school and school years could do much to offset the present nutritional malpractices that are prevalent. There is a good prospect that work recently initiated at Teachers College, Columbia University, and at Harvard School of Public Health can result in a major improvement in giving school children and their parents at least a basic understanding of important relationships between food practices and the development of a healthy physique on the part of the individual. A further great gain could result in improved education of the medical and allied health organizations. The Council of Nutrition of the AMA is increasing its

interest in this regard and the similar encouraging developments are underway at the American Dental Association and the American Public Health Association."

Dr. Jean Mayer of the Harvard University School of Public Health has three rules recommended to retard senescence.

1. Eat a varied diet to avoid any chance of nutritional deficiency.
2. Do not eat too much of it so as to maintain the same weight that you had at the age of twenty-five, and
3. Continue to exercise regularly no matter how busy a schedule you have.

From the Department of Physiological Chemistry, University of California, Dr. Wendell H. Griffith says:

"Physical and mental deterioration in senescence might be postponed or prevented in part by a plan of life, deliberate or arranged that maintains social contacts, physical activity and responsibility for the accomplishment of a job of some sort. Preoccupation with ill health must be avoided at all costs. Specifically, adults (everyone in fact) should learn the advantage of the proper eating regimen that keeps one nutritionally fit and reasonably free from the common ailments of the alimentary tract."

On the subject of dietary regimens, Dr. C. H. McCloy of the State University of Iowa, expressed himself as follows:

"The average individual knows something about an adequate diet, but it is often presented in too complicated a way. I believe that this subject should be so presented that the average layman would know what to do. As I have stated, many people build up large cholesterol values with no warning whatsoever. For example, a man who had apparently been in perfect health found, at the age of sixty-eight, that he had a blood cholesterol value of 365 milligrams; this is extremely high. He was not obese and, in fact, kept his weight at the normal level all of his life; yet, shortly after this finding, with no other suspicious signs, he had a coronary occlusion. Had he known several years before that he had this amount of cholesterol in the blood, he could have reduced it markedly by diet. In fact, this man has reduced it 36 milligrams within one month, and is still continuing to do so. It would seem to me that it would be well worth while to indicate that, if the cholesterol is unduly high, a nonfat diet or some other diet would be desirable. I realize that this is a controversial matter, but it would at least seem to be worth a try; the studies by Keyes would indicate that this may be a life-saving matter.

"It seems not to be known to most physicians that some of the nonsaturated vegetable oils, such as corn oil or soy bean oil added to the diet in appropriate amounts will greatly aid in reducing serum cholesterol.

This has been brought to my attention within the last month at the National Institute of Health in Bethesda, Maryland. Since then I have found a number of cardiologists who did not know this.

"Along lines of dietary regimens I should like to suggest that perhaps the American Medical Association should produce a relatively small and specific manual on nutrition which might be used by the average physician as a 'Nutrition Formulary.' I have been increasingly impressed as the years have gone on with the numerous statements in the popular and medical literature (statements written by physicians) urging the patient to 'see his family physician' when undertaking any diet, whether for reducing or for some other purpose. However, nutrition is one of the areas in which a large majority of physicians have shown a complete lack of training. I do not think we can expect most of these people to read a 700-page book on nutrition, but many would read the germane parts of a nutrition formulary when giving advice on diets to their patients. In view of the fact that knowledge in this field is being rather rapidly extended, I think that such a formulary should be revised every two or three years along the lines of geriatric practice, with the emphasis upon the low fat and high protein diet."

Summary

In the line of a summary and with re-emphasis on certain points already mentioned, Dr. Frederick Swartz, a member of the Committee, had the following to offer:

"What the physical man is or is to be depends on what he eats. How foodstuffs are ingested, digested, absorbed, transported and assimilated for purposes of growth, repair, storage and energy formation is known as nutrition. An adequate diet is one that provides carbohydrates, fats, proteins, vitamins, minerals and water in adequate amounts and proportions to fulfill the aims of good nutrition. In good nutrition the carbohydrates, fats, and proteins yield energy and provide growth. They also maintain the tissues subject to wear and tear, so that the body is kept at ideal weight and the energy reservoir is adequate for the usual demands. The vitamins, minerals and water are an essential part of the chemical mechanism for the utilization of energy and for the synthesis of various necessary metabolites, such as hormones and enzymes. The minerals, in addition to being an integral part of the structure of the body, play an important part in the acid-weight balance. As long as life lasts, the preservation of the physical body in as good a state as possible is one of the major challenges of the aging. This is the job of good nutrition and the reason nutrition is one of the important problems of aging.

"The material for consideration pays tribute to the classroom and the research laboratory. The real textbook, however, has been and will continue to be the members of the aging group and the judgments offered will be those of the gerontologists, not the nutritionists. The problem of the nutrition of the aging will be

considered in the setting in which it exists. The hereditary background, the lifelong habits, the work, the home and the community environment are all facets of the nutrition problem.

"What do we know about the state of nutrition of our aging population? What is the size of the undernourished group? The malnourished? The overnourished? Are the groups large enough or important enough to warrant our attention? If they are, and we find the solution, will not a larger problem evolve—that of improving the standards that we now consider good? In any case, the problem of nutrition in the aging occupies a vital place today and will do so as long as man has a physical body and an interest in longevity.

"Brewer and associates studied the hemoglobin, ascorbic acid, vitamin A, and carotene of the blood of a group of residents at two county institutions in the state of Michigan. They report, 'no mean age differences were apparent until after the age of ninety, at which time mean hemoglobin, vitamin A and, to a lesser extent, carotene values were lower. It was of interest that there are persons of all ages who appear able to maintain normal blood concentrations of these chemicals.'

"Yiengst and Shock found in a study of 126 men, aged forty to ninety, that the serum vitamin A and mean carotene levels show no demonstrable age change. Serum protein concentrations in one Michigan institution gave a mean value of 7.07 grams per hundred milliliter for men, and 7.13 grams for women. These values fall within the normal accepted range.

"Gillum, Morgan, Williams, Kirk and Chieffi indicate that blood concentrations of ascorbic acid, vitamin A, and carotene are similar for both young and old, and depend on the consumption of similar quantities of food supplying these nutrients. About 70 per cent of the Michigan group did not meet the standards of ascorbic acid nutrition, and about 25 per cent had less than 30 micrograms per hundred milliliters of vitamin A in the plasma, but as pointed out by Brewer and associates, less than 10 per cent of the residents studied could be considered to be in poor nutritional state, with respect to both vitamin A and ascorbic acid.

"The physiologic processes upon which life depends do not deteriorate with age. This was demonstrated by Shock in the resting state in his study of the regulation of the acid base equilibrium, fasting arterial blood sugar, absorption of vitamin A, eosinophil response to ACTH, and the patient's ability to retain nitrogen. In a major way, these functions are supported by good nutrition.

"Balance studies done by Bogdonoff, Shock and Nichols indicate that the degree of negativity or positivity of the calcium balance on the low and high calcium diets is of the same order in the young and in the old. Calcium equilibrium can be maintained in the aged on 850 milligrams of calcium daily. As a by-product of this work, data are presented to show that the aged male retains the ability to store nitrogen, phosphorus and potassium and thereby build protoplasm.

"In any discussion of the nutritional state of the aged, some thought must be given to the undernour-

ished, the malnourished and the overnourished. These terms override one another and the difference only becomes apparent when treatment is instituted. The undernourished include those oldsters who are not getting the required amount of carbohydrate, fats, proteins, minerals, vitamins and water in the optimum proportion to maintain the body at ideal weight and function. This situation is best represented by the victim of starvation, caused by one reason or another. The treatment corrects this state by the removal of the cause, if possible, and by the provision of adequate amounts of the six essential food groups listed above.

"The malnourished could really include all variations from the normal standard, more specifically, however, the food fadists, the misinformed and the dietary tyrant come into this group. Getting these people to change lifelong habits is more difficult than getting the undernourished to increase his diet. These dietary ideas are almost as sacred as religious opinions. The malnourished, as defined above, taxes the ingenuity of the nutritionist, contributes to the morbidity rate, and probably succumbs somewhat earlier than the normal because of the absence of some of the necessary elements of diet.

"In the field of the overweight, the data are more definite. Authorities agree that obesity increases the hazards of most of the diseases common to man, and there are certain diseases, such as cancer, found more frequently among the obese. Dr. Edward Bortz of the New Lankenau Hospital says: 'In our experience, cancer occurs three times as often in persons who are 25 per cent overweight as in persons who are normal or slightly underweight when the first sign of the tumor has been identified.'

"Overnutrition is largely typified by the overweight and obese group. Twenty-eight per cent of the United States population is overweight. There are many good reasons to show that obesity is not just due to the simple problems of excessive caloric intake as compared with output. Future research may reveal some mechanism of nutritional utilization which may be a factor in obesity. Work is being done on variations in fat content of overweight people which may sharpen the focus on the problems of obesity and its effect on longevity. The solution of the problem of obesity and its effect on longevity in the aged, like the solution of the problem of obesity in the young, depends on the reduction of the caloric intake and/or an elevation of the caloric output. This requires a wise selection of a low caloric diet with adequate vitamin supplements.

"Undernutrition, malnutrition, and overnutrition must be considered as chronic diseases as we find them in the older population. Most of these situations will have existed for many years. It is likely that the graver nutritional effects are not detected in the older group, as they have probably paid the price of their indiscretions before they could be included in the aged. There is not much evidence to indicate whether malnutrition, as defined above, influences longevity, statistically, one way or another. In the absence of fatal disease, undernutritional states in the aged usually respond well to an adequate diet.

"In general, these variations from good nutrition,

either questionably in undernutrition or very definitely in overnutrition, shorten man's life span. It therefore follows that good nutrition, in the light of the present day knowledge, and subject to such modifications as will be brought about by advancing our knowledge in the future, should contribute immeasurably to increase the longevity.

"What ideally constitutes an excellent nutrition can be mapped out readily enough, but success in this science often depends upon factors quite remote from the utilization of food. From birth to the grave, the marriage of food to man is beset with more qualifying and environmental forces than most any human relationship. The following is a partial list of the factors that influence the nutrition of man as he goes through life:

1. Infant feeding, whether breast or bottle.
2. Too little, too much, or too monotonous food habits in early childhood.
3. Clean plate clubs.
4. Food fads of the individual race or nation.
5. Diversified methods of preparing food.
6. Luscious pictures of food in current magazines.
7. Unending interest of the obese in anybody's reduction diet.
8. The capriciousness of appetite.
9. The willingness to buy anybody's vitamins.
10. Faulty mineral intake.
11. The social implications of mealtime.
12. Overeating associated with anxiety.
13. Overeating associated with gluttony.
14. Overweight and its consequences.
15. The effect of responsibilities at home and position on food intake and digestion.
16. Limitations or excesses afforded by budgets.
17. Vacant chairs around the dinner table.
18. The status of the endocrine system.
19. The presence or absence of chronic illness.
20. The effects of bed rest.
21. Happy, satisfactory employment.
22. Motivation for living.

"Those factors that tend to impair or enhance good nutrition are, by and large, beyond the field of training of the nutritionist. The nutritionist or physician who wishes to accomplish the end of good nutrition will have to broaden his field of activity. The other alternative, to attack these problems as an interdisciplinary one, would include all of the fields of human endeavor.

"In general, this survey of the nutritional problems of the aged can be distilled down to one concept. The nutritional problems of the aging are merely the nutritional problems of man. The nutritional status of the aged person, as observed in practice, is the result of all of the factors influencing nutrition that have been applicable during his lifetime.

"The nutritional derelicts found among the aged should be treated in the light of modern dietetics insofar as possible, irrespective of age. It is a common experience among physicians that the barrier of dietary habits and tyrannical ideas about food are almost impossible to overcome. Here is a field where most can be accomplished by those who can effect the wisest and

simplest compromise. We usually have to settle for less than an ideal arrangement, because more strenuous efforts at treatment cause the patient to break off his relationship with the physician, thus destroying any chance for improvement.

"The attention drawn to nutrition by discussion of the problems of aging brings to light anew and with emphasis, the fact that more attention must be paid to nutrition in the formative years, by a better understanding of all the facts which influence nutrition. By the employment of all the involved disciplines in a great team effort, we should be able to change the food habits of the growing young and bring to advanced years a man who will be more rugged physically with each advancing generation."

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The Changing Scene

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THE Changing Scene has touched many areas of our national life but none more so, it would seem, than our professional activities as they relate to our allied professions and all other areas of American enterprise. To some of these changing scenes I should like to direct attention.

During the last thirty or forty years medical research has come of size, it has grown to true stature, it is big business as a result of imaginative, challenging and loyal co-operative team play. As this is being dictated on the plastic ribbon I am gazing at a small black and white, framed picture of my little one-room laboratory at Boston University. In it I see a small kymograph, a tissue bath, a desk lamp to warm the fluid in the bath, and a few bottles of reagents and solutions of drugs on the shelf nearby. Below, I see a bucket to catch the washings. Gazing at this picture brings back hallowed memories, for in this same little room it was my privilege as student counselor to confer with medical students and staff members alike. As I gaze now toward the other wall I see a large framed document with the gold typed title, "American Pharmaceutical Manufacturers' Association—Code of Ethics," and scintillating as after images I see now through closed eyes the many wonderfully equipped research laboratories of our industry, in our country and the world over, along with all those other excellently equipped and utilized research laboratories in our medical schools and hospitals and research institutes. The scene has changed for all of us in terms of the simple, smoked kymograph and its equivalent, to the electrocardiograph, electroencephalograph, spectrograph, spectroscope, infrared spectrophotometer, Geiger counter, cyclotron and their respective equivalents according to one's special field of interest and research endeavors. Research is big business. Medical research is big business and has achieved this stature because of very intimate and loyal co-operative team play. And during this changing of the scene, you and I in our respective fields of

interest have been most privileged to have taken a small active part therein.

In this connection I read with real pleasure in my weekly anticipated copy of the *Detroit Medical News*, the editorial by Dr. F. P. Rhoades entitled "Partners in Research." I quote him directly:

"The highly trained technical personnel for research comes from many fields; the chemist, the physicist, the bio-chemist, (and may I also humbly include the pharmacologist), the physiologist, the bacteriologist, the pharmacist, the veterinarian, and the clinician. Each is obligated to make his contribution before a new therapeutic agent can be released for general use.

"This team work must, of necessity, include the practicing physician. He plays an important part be he internist, surgeon, pediatrician, obstetrician, or generalist. His careful clinical evaluation of the new agent discloses any untoward effects. These should be reported in writing. Clinical trials also discover additional and unsuspected uses for the new agent. It should be obvious that the product of the original research should be used to the exclusion of substitutes which, rest assured, will spring up as soon as the value of the new agent becomes apparent.

"While the majority of practicing physicians cannot find the time to conduct carefully controlled clinical tests, they can contribute to research by making new funds available through prescribing the products of research. They should not yield to the temptation to use 'something just as good' in the mistaken belief that they are doing their patients a service.

"The research houses" says Dr. Rhoades, "are constantly striving to bring forth ever-increasingly effective therapeutic agents for the alleviation of the multitudinous ills of mankind. We, the practicing physicians, owe them all the support within our power. Let us be part of the research team through the use of new-found therapeutic agents which bear the authoritative stamp of ethical investigators of the research pharmaceutical firms."

How could one have said it better?

The scene has changed in reference to medical publicity or medical writing as evidenced by this occasion when you are honoring members of the press, members of the radio and television media of distribution. This is as it should be. An educated citizen is the strength of our country. Many of you will recall the first and foremost of popular medical writers, a citizen of our state

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and an honorary member of our Michigan State Medical Society and of my local Ottawa County Society, a man whom I am most pleased to consider as one of my best friends, Paul DeKruif. You will recall his *Microbe Hunters*, which to me is still his best work and which I know was one of the main influences in directing many a soul into scientific and medical research and practice. What a joy it must be for Dr. DeKruif to reread on occasion his hundreds of letters telling him just that, "Because of your *Microbe Hunters* I am a physician today." Paul was a pioneer and a lonely one at that, even well beyond the appearance of his *Men Against Death*, which I believe to be his second best. If only these two works were his sole contributions to this important field of medical writing, his prodigious efforts to the present moment notwithstanding, they would suffice to endow him appropriately with the title, "The Forerunner" or "The Pioneer" in this very important field. In our American system of free enterprise we need you medical writers as a "good press," as you need us to press you.

Medical writing in scientific journals has experienced a changing scene but, unfortunately and all too frequently, from a pleasant readable style to that of most straight-laced, corseted and confined routine telegraphic format. Would that our editors would permit even a smattering or smithering of the English style. Frankly, my first choices of medical reading are the British journals. In their writings the author's personality is not always subdued, his style is revealing and personalized, thus captivating the reader's attention while he pleasantly encounters a solid pearl or two.

In this very important educational medium, we need a change of scenery, back to the delightful, personalized style, certainly for those authors who really have something to say.

The changing scene has affected medical education. The old *Materia-Medica* has sublimed into more specific therapy. The old course in pathology has become functional. The diseased patient is now considered as one with aberrant or disturbed physiologic mechanisms. He has been altered biochemically. Anatomy is now being taught as a functional discipline with pathologic and surgical implications. The enthusiastic conscientious internist now frequently returns (or even retreats!) to the laboratory to search further

into those fundamental concepts to which he was originally exposed during his early years of medical training but which at that time did not appear to be of sufficient importance to demand wholehearted attention; only now do these concepts and principles become of great significance in reference to a specific medical or surgical problem. New facts added to old facts pile up to mountains of information which at times seem to be insurmountable, but if facts, important as they are, could be minimized and more fancy be permitted, that is, cogitation, imagination and good old solid thinking which obviously implies that adequate time must be allotted for it, would our future physicians be even better equipped to handle diagnostic problems as they present themselves in general practice? Several medical faculties have initiated and others are now exploring the so-called vertical system of education rather than the horizontal approach, that is, an organ such as the kidney for example is studied successively from the point of view of anatomy, physiology, pathology and therapy; in other words, in logical sequence from a structural, functional, pathologic and treatment point of view, following which another organ or system such as the lung or respiratory system is sequentially studied in a similar manner. This is being done in a laudable attempt to have one see the forest as well as the trees. These educational experiments will indeed be interesting to examine during the next several years.

The scene has shifted in terms of the medical apprenticeship; whereas formerly the country doctor was the devoted medical faculty in the old horse-drawn buggy between calls, his place has been very properly assigned chiefly to full time teachers who make a career of their various specialties. But is there still room for some sort of modified apprenticeship? How much does the average medical graduate know about setting up medical housekeeping from a business or economic point of view? What does he know about the very many unanticipated duties and responsibilities associated with general practice, be they social, economic, religious or otherwise in nature? Could even one month reasonably be spared from, or added to, the present medical curriculum to permit the future graduate to live in, or work with, some busy practitioner in a sort of father-son relationship if for no other reason than to pick up a few pearls of wisdom he never could learn in

the classroom, the laboratory, or the hospital bedside? Should some form of apprenticeship return to the medical scene? In our present position of being so closely scrutinized by the general public, would that very important personal element change the current and all too often undesirable connotation of the M.D. to that of the true physician with all that this term implies?

The scene has shifted and will shift more emphatically no doubt in the closely allied profession of pharmacy. Years ago the professional pharmacist was heavily occupied with the compounding of complex prescriptions, certain ingredients of which might have had some definite beneficial effects, others of which perhaps had little if any therapeutic value. Today the average drug store, (please note that I did not say the average pharmacy), is so cluttered up with beachballs, chewing gum, hair tonics and garden hoses in many instances, that one is almost defied to find the most important unit in the store, the prescription counter. Why must one wade through a maze of nonprofessional five-and-dime type of material to obtain a prescription? The alert pharmacist will soon place his prescription counter in full view either from the sidewalk or immediately upon entrance to his store. This is his lifeblood as it is also that of his customer. Why not make it the most important unit in his shop in order to justify the name of pharmacy? Many pharmacists will tell you that in order to break even or to make a small profit they must carry all these extra gadgets and appliances, but this is highly doubted. Statistics definitely support that pharmacist who has sworn off selling lawn mowers, soup strainers, beachballs and straw hats in favor of ethical pharmaceutical prescription items and the trend today is definitely in the latter direction.* This scene is changing favorably. At several recent meetings of our Board of Trustees of the Columbia University College of Pharmacy, this has been a topic of major interest. It is reasonable to anticipate, I believe, on the basis of these and other discussions, that the future pharmacist may be trained along new lines, and this is where we as physicians might definitely enhance this picture. We have confidence in our better trained pharmacist and we should encourage and support the most professional atmosphere and curricular disciplines possible in this closely allied important profession.

In this respect the professional pharmacists have

been duly recognized en masse by the physicians in this area in the form of an auxiliary group known as The Pharmaceutical Associates of the Wayne County Medical Society. This pioneering effort undoubtedly will be duplicated across the country during the next decade or two. This is truly a favorable change in scenes.

We have come to the last act, in fact we are changing to almost the last scene, that of the newer media for distribution of medical information, namely, radio and television. Last year you honored the latter medium, namely television, by inviting Mr. Leland I. Doan, President of the Dow Chemical Company, to discuss with you the topic: "And Then Came Medic." Most of us have seen "Medic" on one occasion or another and no doubt with mixed feelings of genuine pleasure, surprise, or great or mild satisfaction; seldom if ever have I heard frank condemnation, but such has been reported. The same no doubt can be said of "Medical Horizons," which has been sponsored for the last year and a half by the pharmaceutical company which I represent. Believe me, when I say that such services as rendered by Smith, Kline and French in their program, "The March of Medicine," by Dow Chemical Company's having supported "Medic," by Ciba's sponsoring "Medical Horizons," and by the several other companies which sponsor closed circuit television geared primarily to the physicians assembled in various auditoriums across the country, have come into being only after a great deal of soul-searching and deliberation. Each group, I am sure, has this main theme in mind: we will do this because it will be of more value than harm to the greater number of people viewing our presentation. In our own case, and I am sure it is true of others, we say "The primary purpose of 'Medical Horizons' is to promote better understanding of the doctor as an individual and as a member of the complex team (including allied professions and industry) that protects the nation's health."

Mr. T. F. Davies Haines, our president, amplified this in last Monday night's final telecast in this current series as follows:

"It's teamwork that makes medical progress, many heads, many hands working together. The physician, the surgeon, your family doctor, has with him, the

*"The General Report of the Pharmaceutical Survey 1946-49" conducted by the American Council on Education (page 93).

pathologist, the radiologist, the laboratory technician. Together, these men of science form what we might call a medical army whose dedicated efforts are conquering diseases one after another.

"Ciba hopes that, through 'Medical Horizons' you have gained even greater confidence in your doctor. For today, armed with new techniques, new medical knowledge, new drugs, your doctor can cure diseases considered fatal just twenty years ago. And new medical horizons are opening each day. Progress is encouraging. The future of medicine looks bright. We in the pharmaceutical industry are proud to have a part in this progress being made toward better health."

There is little doubt in my mind that television will be utilized more in the future, for the old physiologic dictum still holds true that "the eye perceives fourteen times faster than the ear." In applying this physiologic principle, obviously our individual and collective responsibilities are great in the selection of the appropriate material to be telecast either for professional, lay or mixed audiences. It is one thing to alert and inform a viewing audience but certainly this must be done with great circumspection. Mr. John Public wants to know, and if he does not find his answer in published media, whether they be the daily newspapers, weekly or monthly periodicals, he will seek it on the radio or via television. This happy circumstance offers all of us a great challenge in terms of mass education of the proper type. Yes, the scene has shifted to include television with the microscope.

And now for our last scene. One of the most significant changes in scenery is associated with recent developments in the field of mental health. As you well know, fifty-one out of every one hundred beds in our hospitals in this country are occupied by patients with some degree of mental illness, minor or major in nature. This

situation presents the greatest challenge ever offered to any professional group with all due respect to those fine Nobel prize winning medical achievements of the past; the latter's great, respective values come into proper focus, however, as one honestly visualizes today's medical Public Enemy No. 1, namely, mental illness. For what profiteth it a man if he should gain a whole and well body but be governed by an ill mind? On the other hand, in direct contrast—what marvelous accomplishments man is capable of when one thinks of Milton (or Helen Keller) for example—keenly endowed with all mental faculties despite the curse of blindness, an imperfect body. What is this world coming to when increasing numbers are diagnosed as psychotics or neurotics of one type or another? How important it is to attack this problem from many points of view, sociologic, spiritual and not the least, medical, and here we have at least some rays of hope in the clinical reports of the last two years concerning the new phrenotropic drugs. Let us hope sincerely that in due course the line of march to the mental hospital may be slowed down while the line from that hospital is accelerated. The challenge is great in the shifting of this scene!

I sincerely hope that my brief words, despite the changing scenes which inevitably lie ahead, may help to solidify and strengthen the professional bonds that bind us with only one thought in mind, to maintain and advance still further the best standards and practice of medicine with the assistance of the best therapeutic agents developed in the research laboratories of our great private, state and industrial institutions, as permitted by the finest system of free enterprise ever designed, the American Way of Life.

ELEVENTH GENERAL ASSEMBLY, WORLD MEDICAL ASSOCIATION

One of the tangible privileges of membership in the U. S. Committee of the World Medical Association is the opportunity to attend its annual assemblies as an official observer for the Committee. With the forthcoming 11th General Assembly to be held in Istanbul, Turkey—the world's "oldest and newest city"—mem-

bers are confronted with a tempting opportunity to visit all the world famous centers of medical lore and historical interest between the Atlantic and the Bosphorus. The dates of the Assembly are September 29 to October 5, 1957. The pre-registration fee of \$15 includes attendance at the annual dinner and an excursion.

Chronic Disease—A Challenge to the Medical Profession

By Otis L. Anderson, M.D.
Washington, D. C.

CHRONIC disease has been described as "one of the last frontiers of medicine." Since the power is not given us to see into the future, I cannot speak for the "last." Certainly, it is a most important medical frontier of today—and will be, for some time to come. The acute illnesses have given way to chronic illness and disability as the major health problem of the nation in this mid-20th century. That the medical profession of Michigan clearly recognizes this transition is demonstrated by the prominence of the subject on the program of your ninety-first annual meeting.

The questions which we as physicians must answer are "What more can we do about this major health problem?" "What *are we going to do?*" This is our challenge!

The Problem

First, I think, we must face the problem in its full magnitude. It is one of staggering proportions. In 1950, an estimated 28 million Americans suffered from disabling and nondisabling chronic disease or impairment. 5.3 million of these people—almost twice the population of the metropolitan area of Detroit—required a prolonged or continuous period of care: at least thirty days in a general hospital or more than three months in another institution or at home.

These are sobering statistics. To the physicians of Michigan this means that well over a million (1,176,000) persons in your state have a chronic disease or other impairment, and that long-term care is required for approximately one-quarter million. These statistics also point out the need for emphasizing the preventive aspects of chronic disease if we are to reduce—or even stabilize—this burden for the future.

It has been estimated that chronic disease results in one-half to three-fourths of a billion man-

days lost from production each year. Chronic disease accounts for public expenditures of \$1.5 billion a year for medical and hospital services, and for an equal amount each year for payment of cash benefits. To the individual, the cost of chronic illness is an even greater catastrophe. In 1952, some half-million families spent between 50 and 100 per cent of the total family income on medical care, of which the largest part was due to chronic disease. Another half-million families were burdened with medical expenses *exceeding* their income.

These figures will continue an upward trend unless we as physicians accept personal responsibility in pushing back the frontier of chronic disease.

Relationship of Chronic Disease to Aging

Since more people are living to the ages at which the chronic diseases occur most frequently, it is natural to associate chronic illness with the aging process. However, we must not be misled into thinking of chronic disease as an exclusive problem of old age. Over one-half of the chronically ill are under age forty-five; more than three-fourths of them are between fifteen and sixty-four. In the ages over ten, more than 60 per cent of the days of disability are due to chronic disease. This proportion rises with increasing age, of course.

During the past fifty years, we have made great advances in the reduction of mortality in the early age groups; but mortality rates among persons forty-five years of age and over, particularly among males, have been reduced relatively little. It is in this group that the greatest waste of human life occurs today . . . waste in years of life lost through premature death . . . waste in years of production through premature disability.

Currently, well over 25 per cent of the entire population has reached or passed forty-five years of age. As the numbers of our aged population continue to grow, the impact of the chronic

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Dr. Anderson is Assistant Surgeon General, United States Public Health Service.

diseases becomes ever more significant—medically, economically, and sociologically.

A New Attitude Toward Chronic Disease

The size of the task might prove overwhelming rather than challenging if it were not now possible to look upon chronic disease with a spirit of reasonable optimism. The defeatist attitude which has prevailed in the past has no place in modern medicine. Physicians who accept their chronic disease patients with resignation and lack of interest, regarding them as nuisances "for whom nothing can be done anyway" are oriented to medical practice of several decades ago. There is continuously being developed new knowledge which makes it possible to render effective relief—if not to provide a cure—for a host of chronic conditions.

Homburger² supports the realism of this positive, constructive attitude in his striking illustrations of progress made in recent years toward mitigating the effects of chronic disease. Among others, he cites such things as new knowledge concerning the rehabilitation of hemiplegics, means for alleviating the distress of advanced cancer, dietary measures for overcoming the poor nutritional status of many aged and chronically ill patients, and modern methods of treating arthritis and osteoporosis.

Unfortunately, many practitioners who encounter these problems daily do not apply or are not in a position to utilize this new scientific knowledge at the bedside, in the office, or the clinic. Although some time-lag between scientific discoveries and their full application is to be expected, we cannot afford to widen this gap by medical apathy.

A Sound Approach to the Chronic Disease Problem

In man's fight against disease, prevention has always been his most desired goal. The progress we have made with respect to acute illnesses is due largely to the tremendous strides made during the past half century in improved surgical procedures, medical techniques, and preventive health practices of both a clinical and public health nature. The knowledge and experience we have already acquired holds rich promise for the reduction of premature disability and premature death from the chronic diseases.

It is my firm belief that the chronic disease

challenge can best be met through prevention—in its broadest sense. To the extent possible, by preventing the *occurrence* of disease; beyond that, by preventing the *progression* of disease and of associated disability.

Positive Action Against Chronic Disease

There have been proposed at least four distinct lines of preventive action, which I, in turn, should like to suggest to you:

We can prevent the inception of certain diseases.

We can prevent the progress of certain diseases by early detection and early therapy.

We can prevent or delay the onset of premature death or premature disability due to known or existing disease through timely diagnosis, treatment, and rehabilitation.

We can join the effort to prevent the destructive social and economic effects of chronic disease on the patient, on his family, and on the community.

You will agree, I think, that the practicing physician has a real responsibility and a golden opportunity in each area. Reparative medicine alone is far from adequate.

We now know that through judicious use of oxygen therapy for premature infants, retrolental fibroplasia can be prevented and that use of mydriatics is to be avoided in the eye examinations of older persons for glaucoma.

The incidence of rheumatic fever can be reduced by instituting early and vigorous penicillin therapy in streptococcal throat infections.

Some neoplasms can be prevented by proper treatment of precancerous conditions or lesions. Others can be prevented by making patients more aware of cancer-inducing agents which might be modified or removed. For example, they should know that excessive exposure to sunlight should be avoided and that industrial exposures to such substances as tar, pitch, creosote, arsenic, radioactive substances, soot, et cetera, should be reduced insofar as possible in order to prevent skin cancers. Likewise, that proper control measures for reduction of air contaminants are significant in the prevention of lung cancer.

Many home accidents—which frequently involve long-term or permanent disability—could be reduced, if physicians, among other professional persons, when visiting patients at home observed and called the family's attention to hazards there which could lead to accidents.

Early detection and early therapy depend upon

development of "a high index of suspicion" for discovery of hidden cases of disease among presumably well patients. All practicing physicians perform varying types of diagnostic procedures. Many are narrow—confined to a given specialty—and do not provide for the discovery of other physical and mental deviations. There are over 200,000 practicing physicians in the United States. Until a majority of them emphasize diagnostic procedures on a broader base of screening—to detect abnormal conditions both among patients who present themselves because of illness and among those who appear for routine or other examinations—little real progress will be made toward prevention and control of chronic disease.

There is available at least one simple blood sugar screening test for diabetes that can be performed in any physician's office in less than five minutes. Relatives of diabetic patients, overweight patients and parents of babies of large birth weight, *in particular*, should be checked periodically for diabetes.

The aspiration method of making a vaginal smear is quick and simple. It is an invaluable tool in the early diagnosis of unsuspected cancer.

Kurlander³ has listed a number of tests and procedures which yield a high return in the discovery of unsuspected disease—simple procedures which can be performed every day in the physician's office or by using diagnostic facilities generally available within the community. If we care to indulge in the popular pastime of the season, we might conduct a poll of this audience to see how many of these tests each of you perform routinely in your practice. The Kurlander list includes:

1. Chest x-ray examinations for tuberculosis, cancer, and heart disease
2. Annual cervical cytologic examination on all women twenty years of age and over
3. Breast examinations of all female patients
4. Blood tests for syphilis and diabetes
5. Intraocular pressure examination of all persons forty-five years of age and over for the detection of glaucoma
6. Anorectal examinations—particularly on male patients
7. Urine testing for sugar and albumin
8. EKG tests for men and women forty-five years of age and over
9. Hearing tests to detect incipient deafness
10. Blood pressure testing
11. Oral examinations to detect dental defects which would have a deleterious effect on health.

As you see, although there is still much we do not know about specific etiology of chronic disease prevention, there is much we do know. Our work is only partially done—our obligation to society only partially fulfilled—if all present knowledge regarding the detection and diagnosis of disease is not fully used.

Equally important is the prevention of *complications* of disease—through modern treatment and rehabilitation. The physician who practices surgery must be aware of the postoperative complications that may follow particular surgical procedures and use every means to prevent them. The orthopedist and rheumatologist must know how to prevent deformities; the cardiologist, how to offset the recurrence of rheumatic fever, and so on through the many specialized fields.

As a cause of death in diabetics, acute infection ranks high. Here, the keystone of prevention, of course, is adequate control of the disease, proper nutrition, and meticulous cleanliness.

We now know that osteoporosis is a disease to be expected in the aged and chronically ill. Through maintenance of a reasonable degree of physical activity, proper dietary measures, and androgen or estrogen therapy, control of this disease can be facilitated. Too often, its existence is completely ignored or merely accepted as being inevitable.

In the not-too-distant past, it was generally thought that a patient with hemiplegia—particularly an aged person—was doomed to spend the rest of his life-span in bed, perhaps in complete immobility. Modern methods of management and rehabilitation have opened the door to restoration of self-sufficiency and sometimes a reasonably normal family and social life for many hemiplegic patients. Yet neither the medical profession nor the lay public seems to be entirely cognizant of how much disability can be prevented by prompt and appropriate treatment. Looking to the ultimate plan of placing the patient in his home environment, full understanding and co-operation of the family is essential. In varying degree, depending upon the extent of disability, it is now possible through several months of intensive rehabilitation to: (1) Prevent deformities or to treat them as they occur; (2) retrain the patient for ambulation and daily activities; (3) develop substitution skills in the unaffected extremities; (4) treat and rehabilitate the affected arm and

hand; and (5) treat loss of speech when this is present.

Even those conditions which at one time seemed most hopeless are now responding to patient, intelligent, and imaginative rehabilitation efforts.

Many Resources Needed for Prevention and Control of Chronic Disease

In the field of chronic disease, the division between preventive, curative, and restorative services is less sharply defined than in the area of the communicable diseases. The doctor-patient relationship is not as simple as in the treatment of an acute illness. Indeed, the whole situation is more complex. Frequently, it is complicated by serious financial, social, economic and psychological implications—not only for the patient, but also for his family, and often for the community as well. The problems are too numerous and involved to be handled by the physician alone.

The significance of this fact—particularly among the aging—was referred to by the outgoing president of the American Medical Association in his address to the House of Delegates in June, 1956. Dr. Hess¹ suggested that a committee representing the medical profession might be used as a nucleus to join with other agencies (both medical and nonmedical) for a complete socio-economic and medical approach to the problem.

First, and possibly most important, among those from whom the physician must have the highest possible degree of co-operation is the patient. The physician may prescribe thoroughly effective drugs, diet, rest, or exercise—but the patient must carry out the prescribed treatment. An entire battery of diagnostic tests may be a routine part of every examination a physician performs, but if the patient visits his physician only when he is ill, and fails to present himself periodically for a general physical examination to determine the status of his health, little benefit will be derived from these good case-finding techniques. It is part of the physician's responsibility to urge his patients—particularly those in the age groups most susceptible to chronic illness—to have periodic examinations as a means of preventing or arresting the development of disease and disability. The attitude of his patients and the extent of their co-operation depend largely on their

general understanding of the nature of disease, its probable effects, and the importance of following their physician's advice. Their behavior is strongly influenced by the confidence they feel in their physician—that he will help them find answers to their health problems, including those of a related socio-economic nature.

A wide range of talents and competencies is needed for broad-gauged prevention and case-finding and for proper long-term care of chronically ill patients. Many professional skills must be carefully co-ordinated and welded into a smoothly functioning team for continuity of service to the patient. A variety of physical facilities and up-to-date equipment will be needed: hospitals, nursing and convalescent homes, rehabilitation centers; x-ray, electrocardiographs, and other specialized equipment. One could go on. Individual and family financial reserves are frequently inadequate to meet the heavy expense of long-term treatment and care, coupled with the associated loss of income. For such cases, it will be necessary to seek the aid of voluntary and official agencies. Major reorientation in the field of community planning and action is essential to meet the total needs.

The health department has an important role in providing assistance in the development of resources to provide the services needed. It may supply a number of them directly, such as x-ray, laboratory tests, home nursing instruction (and sometimes care), nutritional aid, medical social service, and physical therapy.

Mutual co-operation among the patient, the physician, other health professions, the health department, and voluntary health agencies of the community is essential if we are to achieve true prevention and control of chronic disease on a community-wide basis. Occasional, episodic co-operation is not enough. Organized community planning and co-ordination of effort, directed to complete use of existing resources and the development of other necessary services which are lacking, is a basic requirement of a total health program—one which will bring to the people all that modern science has to offer in preventing, minimizing, and controlling chronic disease. Continuing support of such a program by the practicing physician is a challenge to the medical profession, for the physician holds the key to its success or failure. Our traditional practice of

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Chronic Disease—A Challenge to Public Health

By Otis L. Anderson, M.D.
Washington, D. C.

THE PUBLIC health movement in this country has always responded to challenges. At the turn of the century, pioneer health workers responded to the problems of those days—yellow fever, smallpox, typhoid, and the rest—and proved that these diseases could be prevented.

Chronic disease today presents us with the same type of challenge that faced our precursors, who literally developed the public health profession through their triumphs over these major health hazards.

In a nation which, within the past decade, has recognized chronic illness as the paramount health problem, one need no longer plead for acceptance of chronic disease as a legitimate public health concern; it remains rather to identify the manner in which public health workers are already attacking the problem, and to suggest how much more can and will be done in the future. Admittedly, much research is needed to further the progress of community application of chronic disease control practices. However, within the limits of our present knowledge, there is still much that can be done.

Impact of Current Public Health Programs on Chronic Disease

Through its present programs, public health exerts its influence in two ways: (1) on the individual directly, and (2) on the individual indirectly, through his environment. Many activities serve both ends. Efforts to prevent or to minimize the effects of chronic illness must be undertaken at every stage of man's whole life-span. Public health is an operation that extends over the full seventy-year cycle of man's current anticipated lifetime.

To start at the beginning, even before birth,

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Dr. Anderson is Assistant Surgeon General, United States Public Health Service.

research is now being conducted which would alter the carbohydrate metabolism of pregnant women with an elevated blood sugar, and thus alter the uterine environment of the fetus, with the aim of preventing diabetes in later life through preventing early damage to the fetal pancreas.

Next in chronological order would come the whole field of maternal and child health services. These services have been strengthened greatly in recent years, and contribute undeniably to the prevention of adult disease.

The fluoridation of public water supplies, which affects the individual from the day of birth, should help to form future communities where it will no longer be true, as it is today, that 56 per cent of all people over sixty years of age are edentulous.

In fact, all phases of protection of the purity of the water supply, and of the food supply, are traditional public health methods of contributing to the safety of the environment, and thus, indirectly, to the health of the individual.

Still dealing with youth, mental health programs designed for children and young people are doing much, and can do more in the future, to prevent mental illness in adults. And mental illness is one of the major chronic diseases of our day.

Health education comes to mind at this juncture as a traditional public health procedure which contributes to the prevention of chronic illness through the inculcation of good personal health practices. Each year, as we gain experience, we recognize more clearly the role that health education plays in chronic disease prevention.

Vaccination against poliomyelitis is an example of a method designed to prevent acute illness and the crippling effects that individuals would otherwise carry with them through life. This is also an excellent example of how, here in America where team-work is a universal ideal, the public health profession and private physicians have cooperated in the interests of the nation's health.

Public Health Programs on the Horizon

No public health program at the present time gives more promise of effective primary prevention in the chronic disease field than does rheumatic fever prophylaxis. By preventing the occurrence, recurrence of rheumatic fever in children, through penicillin prophylaxis, the incidence of rheumatic heart disease can be steadily reduced. Already physicians in private practice and public health clinics are conducting programs for this purpose in many parts of the country.

The prevention of disability and death caused by accidents is a relatively new public health goal. Now that accidents have come to rank fourth among the leading causes of death in the United States (1954) the problem is indeed an urgent one. The newly-created Accident Prevention Program in the Public Health Service is one response to this challenge. At the state and local levels, much effective work is also being done in this field through studies and programs relating to home accidents, human factors in highway accidents, and accidental poisoning.

The attack on community air pollution, which in the last year has been strengthened through Federal legislation (P.L. 159—84th Congress) and substantial authorization of state and local funds, typifies an environmental problem of acknowledged significance to the individual. Research is now being actively undertaken to explore the possible relationship between community air pollution and various types of chronic illness.

As atomic energy develops into a common source of power for peacetime use, the problems of radiation protection will increase correspondingly, and public health must keep pace. Already important research and planning are going forward in this field.

To conclude this selective listing of current and incipient public health programs that are designed to meet the challenge of chronic disease, I should like to mention the work which for so long has been carried forward in the field of nutrition. Public health is especially concerned with the relationship between diet and the development of chronic disease.

A Look to the Future

The challenge of chronic disease is a challenge to public health because it must be met by our communities, as well as by individuals. It is at the community level that an organized attack

against chronic disease must have its beginning. Implementation must then be carried forward through community coöperation. Preventive, curative, and restorative chronic disease programs are all part of one great unity. Our communities must learn to mobilize and integrate all their resources—both public and private—to be successful in their efforts.

In frankly facing the problem of chronic disease, a community, like an individual, can choose between various alternatives in determining the pattern to follow.

I should like to suggest four different ways of viewing this problem:

1. The individual may reject his health problem and hope it will disappear. Communities may react in the same way, elect to "stay in a rut" and do nothing about chronic disease. This is the easiest way, but, of course, it doesn't solve anything.
2. The individual may take the defeatist attitude: accept his health problem in a spirit of hopelessness. The community may make a similar choice, deciding that this major health problem is simply too big a job to be tackled.
3. The individual, anxious and disturbed about his condition, may turn to self-medication or purveyors of "miracle medicines" for help. This course can be paralleled at the community level by seeking a "short-cut" solution, without serious evaluation of resources and needs, instead of developing a program which will truly solve the community's problem.
4. The individual may accept his health problem in a mature fashion and react in a positive manner. It is to be hoped that all communities will ultimately adopt this alternative, and grapple with chronic disease in an organized and efficient manner.

Before we can, as a nation, move forward into large-scale prevention of chronic disease, community planning must be oriented to the problem. Planning, followed by action, must be participated in by responsible members of the health professions, health agencies, and individual citizens. The team approach is essential. Health departments should provide leadership in developing and mobilizing community resources.

Merely to list the kinds of health services required illustrates the need for coöperative effort. The following services must, in one way or another, be made available: detection, diagnosis,

therapy, care for both physical and mental conditions, nursing, restorative services, medical social services, and health education—public, professional, and patient.

Not only should these services be made available, but they must be carefully coordinated for maximum restoration of health and self-dependence to the chronically ill patient. Medical supervision frequently must be continued over long periods of time—usually without requiring the constant attendance of the physician. Home care of the hospitalized patient needs to be planned while he is still in the hospital; home nursing service while the hospital nurse is still on duty. In many instances, there will be need for a social worker, a physical therapist, an employment counselor, or occupational therapist. Diet restrictions or nutritional problems may require consultation and instruction for the patient and the homemaker. It may be necessary to arrange for employment of a housekeeping aide. Plans for these and other follow-up measures should be part and parcel of the plans for medical service.

Health services must be increased many fold, broadened, and have community-wide support if persons with disabling and handicapping conditions, their families, the community, and the general economy as well, are to be benefited.

Success of the team approach will depend, primarily, upon acceptance of the concept of unity, and recognition of the urgency of finding ways to work together. In a recent talk to the American College of Chest Physicians, the Surgeon General of the Public Health Service* strongly emphasized this point in a way that seems to me most appropriate:

"Group planning and action calls, first of all, for a certain attitude of mind toward the changes that have occurred and the contribution others can make—a tolerance of ways and thoughts which are not necessarily ours; an open mind in the free spirit of science; a ready acceptance of the best from any and every source; an attitude of rational receptiveness rather than antagonism to new ideas."

The "Team Approach" at Work

How does a community proceed in putting the "team approach" to work? What are the specific steps involved in achieving desired "unity of

action?" I should like to propose six fairly distinct steps—though they will not necessarily be taken in consecutive order, for there is much interweaving among them.

Defining the Problem.—First, the problem must be defined. The community plan for positive action will give priority to meeting those needs which have wide local recognition and which offer opportunity and promise for improvement within available resources. This means that one or several segments of the total chronic disease problem will be selected for action. The phase of the problem chosen will be defined as carefully and specifically as possible.

Current Status of Problem.—Once defined, it is important to determine what the community is presently doing to meet the problem—to sound out the interest and concern of community leaders, health workers, and those most immediately concerned, the chronic disease patients themselves and their families. What health services not now available are needed? What resources are available to provide them?

Assessment of Resources.—Concurrently, another planning activity may be going on—the assessment of resources. Past failure to provide needed services for the chronically ill or disabled may have been due to lack of resources. On the other hand, too limited a view of the community's potential ability to meet the needs may have been the cause. Skilled health workers with imagination and ingenuity can often uncover sources of assistance, which have previously been overlooked.

Defining Objectives.—In light of these findings, the program goals will be established. With the objectives determined, actual procedures to be taken to reach them can be planned. For example, in developing a chronic disease program, the first step decided on may involve case finding. It has been well established that, in addition to the many people in a community who are known to be chronically ill or disabled, there are others who have the same diseases without being aware of it. What sort of screening or diagnostic program could practically be carried out in order to identify these unknown persons? How can they be brought under medical supervision? What additional services can be provided to help them

*Burney, Leroy E.: What Can Public Health Contribute to the Private Practice of Medicine? Louis Mark Memorial Lecture, delivered to American College of Chest Physicians. Chicago, Illinois, June 7, 1956.

toward recovery, or to stem the progress of the disease?

Plan of Operation.—Step by step, a plan for action is worked out—one which is within community resources, for which interest and support can be enlisted, and which will move toward the objectives set.

Evaluation.—Continually, as the program develops, there is a careful review of what is being accomplished, the methods of operation, the use of resources—to determine whether other ways are more promising, or better procedures are available. The community must be kept informed of progress, the plan must have the participation and interest of every individual and organization that can aid in reaching its objectives.

In this connection, public health can benefit, I believe, by making more use of the skills of social scientists. In solving the problems of the contagious diseases and sanitation, the scientific epidemiological approach has been eminently successful. There is need today to apply this same kind of thinking in solving the problems of chronic illness. Here, however, the emphasis must shift from primary concern with environmental factors to concern with man himself and the individual physiological changes which affect the state of his health. It is necessary to understand how he acts in matters that concern his health—what motivates him to act as he does. Such information provides the means for bringing about improvement in his health behavior. His active understanding and participation are essential to involving him in the chronic disease program to the extent that medical diagnostic procedures may reflect the need for further services. An adequate scientific approach to solution of the chronic illness problem requires the use of skills, concepts, and techniques of behavioral scientists—psychologists, anthropologists, and sociologists—who apply epidemiological methods to the study of man's behavior.

The Health Department as a Member of the Community Team

As a member of the community team, the public health agency is in a position to give leadership through the initiation of co-operative community planning as previously described. I have reviewed some of the current public health activities which are contributing to the prevention and control

of chronic disease. In developing more comprehensive programs, as may be needed, these activities would become a part of the planned community action.

The health department has an important role in providing guidance and leadership for the development of resources to provide the services needed. It may supply a number of them directly, such as x-ray, laboratory tests, home nursing instruction—and sometimes care, nutritional aid, medical social service, physical therapy, et cetera.

It can also arrange to obtain some collateral services from other sources. The ready availability of these community services is particularly important to the physician when coping with chronic illness in the middle and lower income brackets. Through its broad educational activities, the health department can also supplement the efforts of private physicians in promoting action which individuals must take to protect and improve their own health. Health department nurses through their regular home-visiting programs can smooth the chronic disease patient's difficult transition from the period of intensive hospital treatment to the phase of long-term home care.

In a discussion of the changing health picture in North Carolina,* the state health officer's concept of the role of the health department was summed up in this fashion:

"I again express the belief that we (the public health profession) can work out a program in the control of health problems in the non-communicable field, that will be ethical, acceptable and effective, encroaching upon the prerogatives of none. All public health programs directed against these problems will have but one objective, that is, to promote early private medical care for the patient, and to insure the success of that care, by providing to every physician, where needed, the services of trained personnel, in case-finding, follow-up, and rehabilitation."

It is a sound position, forthrightly expressed, I think. To it, I would add that in carrying out those programs which have long been regarded as more exclusively the health department's responsibility, greater attention should be given to the prevention of conditions which may become chronic.

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*Richardson, William H., *The Changing Health Picture in North Carolina*. The Health Bulletin of the North Carolina State Board of Health. Vol. 71, No. 7, July, 1956.

Evidence on Aging

The modern concept regarding the problems usually associated with the aging process and aged persons has undergone considerable revision since large numbers of physicians have become interested in gerontology and more versatile in geriatrics. Gerontology is the study of the aging process itself and geriatrics is the application of gerontological knowledge to those aging persons who may come under their observation, management and treatment.

Aging is inevitable. Perhaps this is iterating a very old observation but it refers to the passage of time which no one can escape. Many other deterrents to a more desirable aging process can be escaped so that it approaches the normal state. With judicious guidance, more persons than ever before may hope to attain comparatively healthy and vigorous later years. They may hope to avoid some of the mistakes made by older persons in other times and some of the pitfalls along the way to purposeful and healthful mental and physical later life. To be without a purpose in life is to have lost one of the most important reasons for living. To be without health makes all else seem purposeless.

The loss of elasticity which is nearly always a concomitant of the aging process can be forestalled somewhat by keeping active; therefore, complete retirement at any age should be discouraged. The chronological age of sixty-five years at which so many persons retired either voluntarily or involuntarily is not a good criterion for terminating useful work of some kind. It has been outmoded by all the evidence at hand.

The loss of some physical strength should be recognized and adjustments made in the physical work or activity. Putting forth more energy to accomplish the things once done with relative ease is not a rational solution. Work should be changed to conform to the worker's strength. Older housewives or those with heart ailments who should conserve their energy may have their kitchens rearranged so as to save themselves noticeable toil, exertion and extra steps.

The loss of rapid recuperation after exertion is more or less normal among older persons. They tire more quickly and the return to normal following activity is somewhat delayed; therefore, long duty and monotonous work should not be continuous but should be interrupted by rest periods, holidays and vacations.

On the other hand, complete idleness is not a desirable manner in which to promote good health among the aging, and those who choose to do nothing soon become decrepit.

Rich Walls M.D.

President, Michigan State Medical Society

President's



Message

Editorial

GERIATRIC MEDICINE

Geriatric medicine occupies each year a greater part of the physician's time. As more people live to be sixty to ninety years of age, the greater is the incidence of those illnesses most common to our later years. More time than ever before must be given to the clinical problems of aging individuals, and the doctor must prepare himself for this change in his practice.

During the past few years, we have read in these pages, as well as in almost every other medical journal, articles having to do with the treatment of illnesses in the older person. Except for the pediatrician and obstetrician, all specialties must be concerned. The general practitioner, however, will continue to see more people at this age than any other group of physicians and it is for them in particular that state medical journals should provide authoritative as well as practical articles for their reading.

Your Geriatric Committee has felt that anything we could do preventive-wise would be of infinitely more value than treatment after illness had already developed. Three years ago, a whole issue of *THE JOURNAL MSMS* was devoted to a discussion of a wide variety of subjects having to do with preventive geriatrics. It was presented in the form of a panel discussion in which a large number of individuals took part. It served as an introduction to the issues which were planned for the future.

This year, Dr. Fred Swartz, our vice chairman, has again accumulated a great deal of material on nutrition and exercise as it affects health later in life. It is our belief that if health can be maintained, at an optimum level, through the application of good preventive measures, the development of many of the illnesses of the older person could be prevented.

In a subsequent issue, it is planned to present another discussion with particular emphasis; this time, upon the psychosomatic, emotional and psychiatric factors affecting the lives of older people.

We believe with Anton J. Carlson, there is reason to hope that with continuing study and better application of what knowledge does exist not only can the life span be extended further but

also the period of usefulness to the community may be prolonged. Longevity without continued health and usefulness is not a blessing.

A. HAZEN PRICE, M.D.

JUNE IS MULTIPLE SCLEROSIS MONTH

Despondency and despair have always been associated with multiple sclerosis, due mainly to ignorance or misinformation of the true facts. Even in places of good repute, the patient in his search for a "cure" is invariably told that nothing can be done for him, thus robbing him of all hope. This hopeless attitude, adopted by the patient, is the challenge taken up by the Michigan Multiple Sclerosis Center. Here a ray of hope is given to him; not a promise of a cure, but a treatment which enables a better way to maintain a relationship with his environment than he had before.

This Center is unique in that it devotes all its time and energies to multiple sclerosis alone. The best of facilities for medical diagnosis and treatment are provided. Research is also continually in progress in the field of multiple sclerosis. Better public relations are being established by means of distribution of literature, presentations of TV programs, and lectures which point out that the outlook is far from hopeless.

Because of the multiple disabilities associated with this disease, a very efficient, sympathetic, and well-trained staff is essential for treatment. Involvement may cause ataxia, spasticity, speech and visual defects, incontinence, and other disabilities. Another factor which makes it difficult to work with this type of patient is that some have a great fear of falling due to previous falls and will not be co-operative when being treated. Others are over-anxious to improve, so take foolish risks when moving about and will not heed warnings. Many ask a great number of questions concerning their condition which require a good deal of wisdom to answer. Those working with these patients must not be too encouraging, thus raising false hopes, or too discouraging, thus causing despondency. A compromise must be made to give comfort to the patient.

GABRIEL STEINER, M.D.

BASIC BLUE SHIELD PRINCIPLES

The medical prepayment program of the whole medical profession was based on a few fundamental principles. The concept became established before a vast percentage of our present active members ever finished medical school. Hopefully, they will never again see conditions like those that confronted us then. There has probably never been a time in historic memory when comprehensive or even adequate medical care was available to all our suffering people. The well-to-do and the securely employed persons could and did have the services of the medical practitioners with the best knowledge and facilities available at that time.

The indigent have always been with us, and in most instances there were charitable hospitals to which they could go. In modern times, the state has assumed responsibility and provided for these same people through the social welfare departments.

Long continued years of desperate want and frustration proved that even the reasonably employed persons found that medical conditions calling for hospitalization could become calamitous. Michigan doctors (and others) evolved Blue Shield and Blue Cross to ensure medical and hospital care for all with foresight enough to subscribe and contribute small payments in advance. Under-income-limit persons only were to be accommodated. The very first group proved there could be no prohibition to the ones just over this arbitrary income limit. In order to insure and guarantee service to the really needy, it was better that some others also be protected. Unauthorized usage might develop, but the profession believed the great benefit to the most worthy was our conscientious duty. The immediate success of prepayment for services—not insurance—was adequate proof of the foresight and dedication of medicine's pioneers in an utterly new field of service.

THE CHANGING TIMES

Nearly two decades have passed. Economic, social and political conditions are different. A new generation is now enjoying almost unbelievable advantages as compared to the times which fathered the Blue Cross-Blue Shield economic miracle. Practically anyone who wishes may have a job, with reasonable hours of work and suffi-

cient pay to care for his family, especially if he has moderate forethought. Medical care of the highest quality is available when and if needed. We also have a new generation of doctors who never saw hard times. They finished school after the great depression, never knew the tedium of waiting in their offices for their first paying patient; never went through the rigors of trying to collect for services gladly rendered but long after the patient and his family had forgotten the anguished pleas, "Doctor, spare no expense." "Insurability" of medical care was an established fact, with large percentages of the population "insured."

Far too many doctors and far too many patients are mistaking the advantages now available as just a "rich insurance company" which can and will pay even unauthorized, or unincluded claims. They do not remember, or charitably do not know, that the voluntary prepayment medical care plans are not insurance companies but actually ourselves, our own medical societies selling our own actual services to our own patients! Selling these services in advance of need instead of the age-old custom of caring for the patient and then rendering a bill weeks or months later. In thinking of some physicians, due to the present prosperity, even the need of prepayment health insurance plans has become obsolete. Recalling such facts, and dedicating our efforts to the needful care; being available when called; not using unnecessary diagnosis or treatment factors will again place our profession in the kindly affections of our patients.

GOVERNMENT CARE

Government medicine is spreading all about us, and the future doesn't look to be much different. A sizable portion of the old Wagner-Murray-Dingell bills have been enacted piecemeal during the years.

Besides the members of the armed forces and other governmental quotas which are necessarily given government medical care, many of the families are being included in the new Medicare. Of our 22.5 million veterans, uncounted numbers are eligible and are getting free care in the Veterans, Hospitals. Each Congress presumes a number of conditions to have been "service-connected." Care for older people is increasing. It now covers many millions who have inadequate resources, some

are on Social Security and some on relief. It has recently been proposed to give OASI persons up to sixty days hospitalization per year which, including Medicare, might add another 14 million persons to the government medical care burden.

A new Dingell bill levying a percentage tax on every employed person and his employer is in the making. It sounds inoffensive. A new government bureau in HEW will pay the bills for doctors and hospitals. How long can that last before doctors will be under coercion, working for the government, and reportable to the government? The world has now reached another and different economic socio-medical era which calls for a brand new deal.

Some form of prepaid insurance has been proposed by the HEW officials to care for the aging and the marginal groups who just cannot provide for or anticipate medical needs. "Coinsurance" was suggested and abandoned. It is claimed that existing insurance cannot cover this need without help—that is true—but Blue Shield, which is service and not insurance, has always provided that any person in a group no matter what his age may continue as an independent subscriber when he retires from the group. A person over sixty-five may not join as an individual, but may in a group of employed persons.

Years ago, the Michigan State Medical Society expressed the opinion that when government is paying for medical care for its wards, they are no longer indigent, and the medical care as well as food, clothing, and shelter should be paid on an acceptable rate, not cut in half as had been the custom. The society, therefore, established a fee schedule for government agencies.

Government could recognize the facts of life and contract to use the available insurance principle to care for its economically uninsurable.

FAULTS AND REMEDIES

The Governor's Committee last year uncovered widespread demand for more extensive care than Michigan Medical Service is now giving and some serious criticisms of the too frequent extra charges being made. Labor has demanded certain office and out-patient diagnosis and care, together with a guarantee of full coverage under the contract. Labor has started to organize its own service plan, stressing groups and clinics with salaried doctors and a prohibition of all extra charges.

A fast-growing complaint, possibly inspired, is the difficulty of getting doctors to make calls after hours or at night. This is serious, and some cities are making efforts to have certain doctors on special call every night.

All these complaints and criticisms point to another "big look" on our part. Twenty years ago, the profession was in trouble from several sources and solved its problems then by united and concerted efforts as a cohesive body. Blue Shield and its administration was the answer. Now we seem to be in trouble again. Some farsighted members are trying to show the road to light. They have analyzed the situation, made repeated and extensive studies and are now proposing a new evaluation. We need not only leadership, *but sacrifice of personal and individualistic ideas and a united front.* The "enemy" is clearly outlined. The basic contract of Blue Shield with some modifications is still the primary anchor. "Comprehensive" or at least well-extended services, office and out-patient surgery, laboratory diagnosis, consultation, assistants, diagnostic and therapeutic radiology must be made available. The medical profession must also reinstate itself in love and respect by always being available for emergency calls. Someone should be ready if the doctor called is busy. Our most numerous competitors have seen this opportunity, grasped the chance and taken too many of our patients.

Our first and foremost duty to our patients is the very best medicine of which we or our confrères are capable. We have been taught all the methods of diagnosis, how to interpret laboratory and other intelligence and are freely using our facilities. However, we were not generally told how expensive all these tests are, or how little money a family is likely to have after paying the ordinary running expenses. We should all have been taught—and should all remember—never to order or inflict an unexpected and unnecessary expense unless we are looking for a "new deal" with some pressure group, or government, pulling the strings. Our second duty is to the patient's economic ills. Response to that duty in the 1930's created Blue Shield.

VETERANS' CARE

Care of veterans with service-connected disabilities is to be continued. The Michigan Plan was developed about ten years ago involving sim-

plified and short report forms. The program continued for years but finally there were only eight states still active. The disabled veterans work in other states is on direct contract between the doctors, the patients and the government, mostly being through Veterans' Hospitals or Clinics. About a year and a half ago, the director of Veterans' Affairs notified all the states involved, that the program would be discontinued as of last July first. Conferences in Chicago by the State Medical Societies and Medical Service Plans involved resulted in a visit to Washington, a hearing, and a revocation of the termination notice. Recently, a new order came from Washington again terminating all service-connected veterans' hometown care through the Societies and Service Plans. Another committee meeting in Chicago, this time with the AMA having an observer, another visit to Washington, various lay representatives from several states, Michigan sending three doctors, and South Carolina sending one, again met with success. On March 13, word came of the complete success of the committee and the adoption for all areas of the Michigan Plan of Care. The veterans' service-connected hometown medical care will continue.

The short, logical forms developed by John Castallucci at the very first have proved adequate and are being used and printed by the Federal Government. In return, these eight states and Hawaii have agreed to a uniform contract, which really is a benefit to the Veterans Administration.

NOTE: Word from Washington April 17, 1957, indicates uncertainty and the necessity for more conferences.

BLUE SHIELD COMMISSION

The annual conference of the Blue Shield Commission was held in San Francisco, March 24 to 28, 1957. Robert L. Novy, M.D., of Detroit, presided as national President. The meetings were attended by the Commission and by trustees, administrators and staff members who seemed obligated or who could go for the semi-vacation. It was an intensive program of the working variety.

The Blue Cross Commission held its conference simultaneously. Present and taking part were R. L. Novy, M.D., Jay C. Ketchum and C. D. Moll, M.D., all of Detroit. There were twenty-seven prepared speeches in Blue Shield and twenty-three for Blue Cross by eminent men in their respective fields—university professors, government officials, plan directors and labor representatives.

Speeches, discussions and bull sessions developed a few important facets of the voluntary medical and hospital programs. We were told that in general the voluntary programs are doing a good job, not over-priced—rather the opposite, and with some effort can be sold to a much more critical public than in the past. There is danger that we may make our plans so expensive that people in the ordinary buying class, the workers, and employees who must live on their earnings will be unable to buy. From all over the nation come problems and questions of policy or procedure, demands here, complaints there. Some facts are outstanding:

1. Labor is complaining bitterly that our plans are not inclusive enough; that the doctors make too many overcharges; that no prophylactic service is offered; patients too often hospitalized for the convenience of making several calls at one place; or the difficulty of getting the doctor at night.
2. Most of the members thoroughly believe that Blue Shield is not insurance run by an insurance company with plenty of money and more if that is not enough, but that it is our own medical society operating in a different field, rendering just as important service to our patients and their needs. We should never change that belief.
3. There is a tremendous necessity of educating our members to the fact that since the medical profession has demonstrated the feasibility of prepaid medical service, we must not now surrender to the numerous handicaps and hindrances being displayed, but must again demonstrate to our public that the medical profession is ready and can meet this present obligation.
4. The insurance counsellors, the State Commissioners of insurance, all believe our plans are in fact insurance, for they are most of them administered by the state insurance commissioners, even if their enabling acts do classify them differently. We must all follow insurance practices, rules and laws.
5. It is the universal belief that Blue Shield and its counterpart, Blue Cross, in the early forties did stop the firmly determined pressure toward compulsory health insurance administered by the Government and stopped socialized medicine. This was done by concerted and determined objective action.
6. Many of our speakers expressed the conviction that the independent practice of medicine in

the well-recognized American style is again in utmost danger from several sources: pressure groups, bureaucrats in the government, demands by the lower income persons for more assurance of full care; resentment against some very obvious mispractices.

7. The pioneers of yesteryear who carried the burden in the past score of years are just as enthusiastic and confident that the men of medicine still have the vigor, the daring, the confidence, the knowledge, the same dedication and genius to find again the true path to preserve once again the American way of life. They believe the public will respond.

8. In the past experience, there were many sacrifices of personalities and individualities accepting ultimate good as most necessary. More sacrifices are needed and will be just as willingly given.

Gleanings

Blue Shield's basic philosophy is service to subscribers, mainly aimed at lower income groups. *It is much better to endure a few abuses or misapplications in order to make sure the worthy and needy will not fail to receive their just benefits.*

HEART SPECTACULAR

Millions of people saw Jim Blodgett operate on mitral stenosis as presented over WWJ-TV. For weeks afterwards, this was the topic of conversation. In their own living rooms, people saw the ultimate in surgical miracles. Drama of life and death—life triumphant! What the public didn't see was the antecedent work, laborious research that preceded the skillful presentation of operative victory of the modern knight. He is the first to acknowledge his obligation to his contemporaries and those who have gone before. And the doctors of Michigan are in the forefront of those who unravel the mysteries and contribute to the understanding of the heart.

In 1896, George Dock, professor of medicine at the University of Michigan, published the first report in the English language of the clinical features of coronary thrombosis and myocardial infarction, the second report in the world literature. It was two generations later that this understanding was diffused to the medical profession. We never saw a clinical case of coronary thrombosis at the University of Michigan when we were stu-

dents. The great Warthin showed them to us at the autopsy table. What medicine owes to Warthin!

Next at Michigan is Wilson. No further identification is necessary for physicians any place in the world. He is the most famous throughout the world of Michigan medical teachers. An authority on the heart and teacher of electrocardiography, he made available to physicians the understanding and use of this instrument. In 1934, Wilson and his associates reported the use of the central terminal for obtaining so-called unipolar electrocardiographic leads, chiefly precordial leads. In 1929, a patient who required surgical drainage for suppurative pericarditis afforded an opportunity for Paul Barker of Wilson's group to stimulate the exposed ventricles electrically and record the responses electrically; these observations by Barker led to a correction of the previous erroneous interpretation of bundle branch block curves. Wherever physicians treat the heart, they are familiar with the great names of Wilson and Barker.

In 1938, Wilson and F. D. Johnson were the first to record vector cardiograms by means of the cathode ray tube. Johnson succeeded Wilson in the famous chair in cardiology at Ann Arbor.

Detroit workers have contributed with distinction in the understanding of the heart. Everyone is familiar with the work of Gordon Myers as researcher and teacher, professor of medicine at Wayne State University Medical School. His lectures on electrocardiography are a worthy succession to those of Wilson. Myers has published books on the electrocardiogram and his papers on correlation of the electrocardiogram and infarction are said by Prinzmetal to be the most significant published. His post-graduate courses on the heart draw attendance from all over the United States and abroad.

With the development of modern anesthesia to equal status with surgery, operations are routine that were previously only dreamed about. With modern anesthesia, pumps for shunting the blood around the heart and oxygenating and returning to the body can be used. In Detroit, Dodrill, of Harper Hospital, led the way in developing the heart pump with which he was able to pioneer in heart surgery.

Any mention of heart at Harper Hospital brings to mind the large series of Gene Osius in vascular surgery. And always mentioned are the many

EDITORIAL

students and practitioners who are obligated to Bob Novy for learning about the diagnosis and treatment of coronary heart disease; he has the diagnostic drive interest of youth, aggressively learning, tempered with the maturity of judgment that comes to those of great experience. A great name, Novy.

At Ford Hospital, Szilagyi is doing impressive work, removing diseased aorto-iliac and femoral occlusions and replacements with homografts and woven chemical substitutes! New aortas for old! Also Ziegler, of Ford Hospital, has clarified the subject of infant cardiology and the congenital heart. He utilized cardiac catheterization, without which the understanding and operations on congenital heart lesions could not be undertaken. He is the author of a textbook on pediatric cardiology; pediatric electrocardiography. Janny Smith brought Detroit to notice and prominence in heart circles with his oft quoted work on anticoagulants and coronary thrombosis; he has been the moving force in development of understanding of heart disease at Ford Hospital.

In rheumatic heart disease in Michigan, there are two outstanding men. Rosenzweig, of Children's Hospital and Detroit Receiving Hospital, has a series of more than a thousand cases, and his clinical teaching of rheumatic heart disease and congenital heart disease has made commonplace what used to be an intricate puzzle. He has given a lifetime to the care of sick rheumatic children. Clarke, of Providence Hospital, has focused on the understanding of rheumatic heart disease and its treatment. He is very proud that he has one of the few M.S. degrees in cardiology presented under Wilson of Ann Arbor. He has been working on the di-hydroxy and tri-hydroxy homologues of salicylic acid in treatment of rheumatic fever. He is one of the first to note that T-wave changes resulting from severe blood loss in intestinal hemorrhage could mimic coronary heart disease in the electrocardiogram. He is now doing work of promise with versine in atheromatous vascular lesions in angina and cerebrovascular strokes.

At Receiving Hospital, the teaching hospital of Wayne State University, in addition to Gordon Myers' monumental work in medicine, there is Harper Hellems who trained a whole group in cardiac catheterization. As mentioned, it is work like his that makes feasible a bold surgical approach and cure of the cardiac cripple. The sur-

geons, Jacobsen and Wible, at Receiving Hospital under C. G. Johnson, have been busy in heart research. Their latest achievement is the use of a spring valve inserted in the heart to correct mitral insufficiency.

Michigan has made history and is writing its chapter on heart disease—its understanding, treatment and cure. We thank Jim Blodgett for dramatizing on television the achievement of all these medical doctors.

DAVE SUGAR, M.D.

CORRECTION

In the March issue of THE JOURNAL, page 360, appeared an editorial entitled "Deaths Balance Births," which should have read "Deaths Around Birth," dealing with the perinatal time. We have checked the galley proofs which did read "Deaths Around Birth." How this change occurred we have no explanation, and we had no knowledge of the change until our attention was called to it by Dr. Goldie Corneliuson. We are making this explanation so that our readers may mark this correction in their copies of THE JOURNAL.

EDITOR

MSMS ANNUAL MEETING

September 25-26-27, 1957

Civic Auditorium, Pantlind Hotel

Grand Rapids

→ Make your hotel reservation now ←



Record Set!

Michigan Clinical Institute Success Story

The excellence of the scientific program, the widespread advance publicity and the extraordinarily favorable weather contributed to the outstanding success of the 1957 Eleventh Annual Michigan Clinical Institute—a meeting which used to be known as the "little session."

Attendance at this year's meeting, held traditionally in Detroit, surpassed 1956 totals by 766. Doctors of medicine registering during the three-day postgraduate session numbered 1,654, an increase of 231 over 1956. Guest registrations soared also to a total of 845, including dentists, veterinarians, nurses and medical students.

High point in the week's events was the telecast to the general public of a live mitral commissurotomy operation performed by James B. Blodgett, M.D., Detroit, from the operating rooms of The Grace Hospital, on Tuesday, the eve of the MCI opening. The hour-long program was carried by WWJ-TV in compatible color. Lansing area viewers also watched the significant display of the techniques of modern medicine by means of a network hookup. Subsequently a kinescope of this program was used on several other Michigan TV stations.

The program marked the first time an actual operation had been broadcast live to the public in Michigan and was the second such telecast in history.

Sponsors were the Michigan State Medical Society, Wayne County Medical Society and the Michigan Heart Association, in co-operation with Smith, Kline & French Laboratories, technical producers of the show.

Chairman of the MCI Television Committee was Dan W. Myers, M.D., of Detroit. The Committee was also responsible for the closed circuit clinical TV





programs broadcast daily from the Grace Hospital to the main ballroom of the Sheraton-Cadillac Hotel on Wednesday, Thursday, and Friday, through the courtesy of Smith, Kline & French.

Also lending color and technical information was the American Cyanamid Corporation exhibit featuring continuous colored motion pictures of clinical and surgical procedures.

Because of a bulging program, presentation of papers by thirty leading medical authorities began at 8:30 a.m. in order to accommodate speakers and the daily clinical television programs.

Formal presentation of Michigan's Foremost Family Physician Award was effected on Thursday noon at a special Testimonial Luncheon honoring both medical and lay persons for their accomplishments and contributions to health and medicine. The luncheon was arranged by G. B. Saltonstall, M.D., who served as toastmaster. Arch Walls, M.D., MSMS President, presented the awards to the honorees.

Ralph G. Cook, M.D., venerated Kalamazoo doctor, sportsman and Indian Chief, received the Foremost Family Physician award following his selection by the MSMS House of Delegates in September. An identical citation was awarded posthumously to Joseph H. Sherk, M.D., of Midland, who passed away shortly after his nomination. Mrs. Maurice Ittner accepted the scroll for Doctor Sherk's family, as a representative of the Woman's Auxiliary to the Midland County Medical Society.

Special tribute was paid to eight Michigan doctors of medicine who are currently serving as presidents of national medical organizations. Those honored were: J. S. DeTar, M.D., Milan, American Academy of General Practice; Ann Arbor doctors, Cameron Haight, M.D., American Association for Thoracic Surgery; Norman F. Miller, M.D., American Gynecological Society and William D. Robinson, M.D., American Rheumatism Association; and the following doctors from

1957 MCI Registration

Here is the final tabulation of registrants at the Eleventh Annual Michigan Clinical Institute at the Sheraton-Cadillac Hotel, Detroit, March 13-14-15.

Doctors of Medicine.....	1,654
Nurses	334
Guests (dentists, medical students, veterinarians)....	845
Exhibitors	410

TOTAL3,243





Detroit, Charles G. Johnston, M.D., American Association for the Surgery of Trauma; Rupert C. L. Markoc, M.D., American Academy of Tuberculosis Physicians; Edgar E. Martmer, M.D., American Academy of Pediatrics; Robert L. Novy, M.D., National Association of Blue Shield Medical Care Plans.

Distinguished Health Service awards were also presented at the luncheon to non-members of the medical profession. Mr. Jay C. Ketchum received an illuminated scroll from MSMS for his nationally recognized leadership in the field of prepayment medical service. Five other awards went to: Labor Commissioner John Reid for his many years of service as a Director of Michigan Medical Service; Representative Arnell Engstrom, Senator Clarence F. Graebner, Senator Perry W. Greene, and Senator Elmer R. Porter. The members of the Michigan legislature were recognized for their support of the finer principles of medical education and medical care as chairman, respectively, of the House Ways and Means, The Senate State Affairs, Senate Public Health and Welfare and Senate Appropriations Committees.

One Outstanding Health Service citation was awarded this year to Radio Station WHAK, Rogers City, for two years broadcast of health information programs. The scroll was accepted by the station's president Harvey A. Klann.

The guests at the Testimonial luncheon heard an address by Wayne State University President Clarence F. Hilberry, Ph.D.

Several MCI speakers were honored at special luncheons on Wednesday and Friday. L. Henry Garland, M.D., San Francisco, and Charles B. Huggins, M.D., Chicago, were presented with citations at a special luncheon Wednesday, sponsored by the Michigan Division and the Southeastern Michigan Division of the American Cancer Society. J. W. Hubly, M.D., of Battle Creek, served as chairman of arrangements.

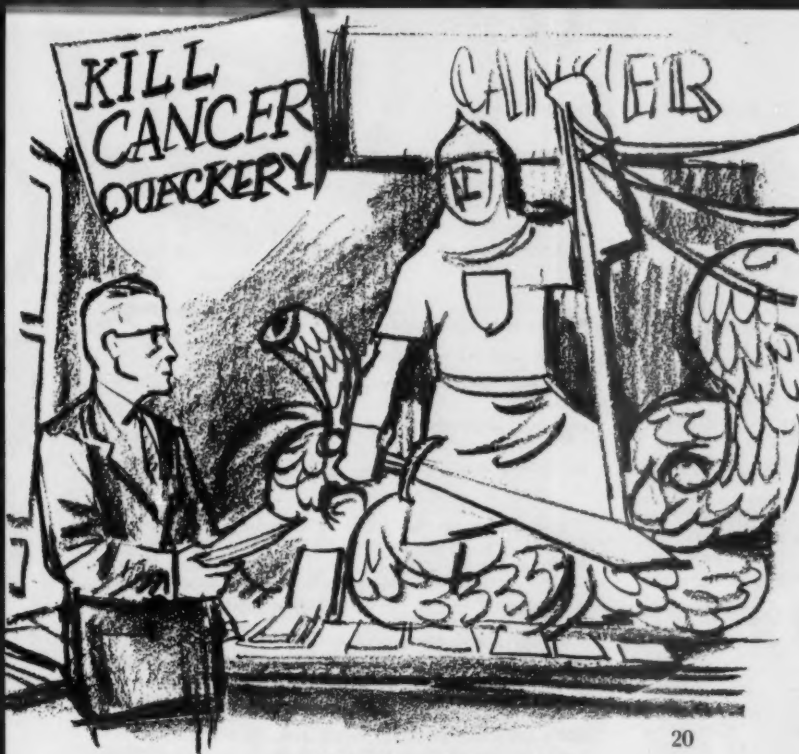
On Friday, March 15, the Michigan State Pharmaceutical Association honored Mr. George P. Larrick, of Washington, D. C. Mr. Larrick is the Commissioner of Food and Drugs of the U. S. Department of Health, Education and Welfare.

Howard B. Sprague, M.D., of Brookline, Mass., was the guest speaker at the public Annual Meeting of the Michigan Heart Association in the Sheraton-Cadillac Grand Ballroom. The subscription dinner was attended by more than 250 guests who saw The Honorable Charles E. Wilson receive a scroll of appreciation for his service to the organization as Board Chairman.

In all, seventeen meetings of special societies, alumni and ancillary groups were held in conjunction with the MCI.

An important sidelight of the MCI was the Wednesday night Panel on Tranquilizing Drugs held in the Grand Ballroom and featuring a panel of doctors from the University of Michigan: R. W. Waggoner, M.D., R. W. Gerard, M.D., and J. G. Miller, M.D.

News interest in the week's scientific activities was unprecedented. Stories on



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Identification of Illustrations*

1. Julius Bauer, M.D., Los Angeles, Guest Essayist.
2. Fredrick C. Swartz, M.D., Lansing.
3. A. Hazen Price, M.D., Detroit.
4. Howard B. Sprague, M.D., Brookline, Mass., Guest Essayist.
5. Wm. M. LeFevre, M.D., Muskegon, Guest Essayist and Program Chairman, MCI.
6. General view close-up.
7. Sen. Clarence F. Graebner, Saginaw, Distinguished Health Service Awardee.
8. Sen. Perry W. Greene, Grand Rapids, Distinguished Health Service Awardee.
9. Sen. Elmer R. Porter, Blissfield, Distinguished Health Service Awardee.
10. Ralph G. Cook, M.D., Kalamazoo, Michigan's Foremost Family Physician.
11. Rep. Arnell Engstrom, Traverse City, Distinguished Health Service Awardee.
12. Jay C. Ketchum, Detroit Executive Vice President, Michigan Medical Service, Distinguished Health Service Awardee.
13. Gilbert B. Saltonstall, M.D., Charlevoix, Chairman, MCI Testimonial Luncheon.
14. Claude L. Weston, M.D., Owosso, Member, MCI Press Committee.
15. A. B. Gwinn, M.D., Hastings, Chairman, MCI Press Committee.
16. Otto O. Beck, M.D., Birmingham, General Chairman, MCI.
17. L. Fernald Foster, M.D., Bay City, Secretary, MSMS.
18. Ralph W. Shook, M.D., Kalamazoo, Chairman, MSMS Finance Committee.
19. Arch Walls, M.D., Detroit, President, MSMS.
20. Cancer Exhibit—B. E. Luck, D.D.S., Lansing.
21. Maternal Health Exhibit—Charles A. Behney, M.D., Michigan Department of Health, Lansing.
22. Lester P. Dodd, Detroit, MSMS Legal Counsel.
23. Wilfrid Haughey, M.D., Battle Creek, Editor, Journal, MSMS.

*See preceding pages for illustrations numbered 1-19 and 22-23.

the MCI, and particularly in the live heart operation, began appearing a week in advance in papers all over the state. Individual stories on the scientific papers were still running in Detroit newspapers on Saturday. And reports on the "heart" patient's recovery appeared as late as two weeks after the meeting.

Assisting the various news media in obtaining information and arranging interviews was the Press Relations Committee; A. B. Gwinn, M.D., Hastings, Chairman; H. F. Dibble, M.D., Detroit; L. R. Leader, M.D., Detroit; J. J. Lightbody, M.D., Detroit; Ralph W. Shook, M.D., Kalamazoo; and C. L. Weston, M.D., Owosso.

Co-sponsoring organizations, who played an important part in the success of the 1957 MCI include: Michigan State Medical Society, the medical schools at University of Michigan and Wayne State University, Michigan Cancer Co-ordinating Committee, Wayne County Medical Society, Michigan Heart Association, Michigan Foundation for Medical and Health Education, Michigan Chapter—American College of Surgeons, Michigan Regional Committee on Trauma—American College of Surgeons, Michigan Department of Health and Michigan Public Health Officers Association.

help DOCTORS

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REPORT OF KNOTSMAN & SMITH, CPA—1956

The Council, Michigan State Medical Society:

Pursuant to your request, we have examined the Statement of Financial Condition of the MICHIGAN STATE MEDICAL SOCIETY, Lansing, Michigan, as at December 24, 1956, and the related statements of income and expense and fund transactions for the year then ended. Our examination was made in accordance with generally accepted auditing standards, and accordingly included such tests of the accounting records and such other auditing procedures as we considered necessary in the circumstances.

In our opinion, the accompanying Statement of Financial Condition and related statements of income and expense and fund transactions, present fairly the position of the MICHIGAN STATE MEDICAL SOCIETY as at December 24, 1956, and the results of its operations for the year then ended, in conformity with generally accepted accounting principles applied on a basis consistent with that of the preceding year.

KNOTSMAN & SMITH
Certified Public Accountants

Lansing, Michigan
January 7, 1957

The following comments are submitted relative to our examination of the MICHIGAN STATE MEDICAL SOCIETY, Lansing, Michigan, for the year ended December 24, 1956.

HISTORY

The MICHIGAN STATE MEDICAL SOCIETY was organized on September 17, 1910, under the laws of the State of Michigan, as a non-profit corporation. The charter has been extended for a period of thirty years from September 17, 1940. The Society is affiliated with the American Medical Association, and it charters county medical societies within the State of Michigan. The purposes of the Society are the promotion of science and art of medicine, the protection of the public health, and the betterment of the medical profession. In the furtherance of these purposes, the Society publishes "The Journal of the Michigan State Medical Society."

COMMENTS

The regular society bank account maintained at the Michigan National Bank, Lansing, Michigan, was confirmed by direct correspondence with the bank as at December 24, 1956, and the balance thus obtained was reconciled to your books of account.

The balance in the Treasurer's account is in accordance with a letter from the Michigan National Bank, Grand Rapids, Michigan, dated December 28, 1956, addressed to Mr. Robert Roney.

Cash in the Lansing office, in an amount of \$36.61, was counted by our representative. Detroit petty cash of \$50.00 was not verified.

Confirmation of Accounts Receivable have been mailed. A very small number of replies have been received due to the early date of this report. Any negative replies will be reported to your office. An aging analysis of the accounts by the month of charge is as follows:

October, November, December.....	\$22,265.52
July, August, September.....	528.20
Over Six Months.....	119.99
TOTAL.....	\$22,913.71

Insurance premiums due from employees are reimbursed to the Society via a payroll checkoff.

A summary of the 1956 premium cost is as follows:

	Total	Society Share	Employee Share
Premium—1 year.....	\$19,718.84	\$10,640.21	\$9,078.63
Refunds and Adjustments.....	1,437.11	849.60	587.51
Net	\$18,281.73	\$ 9,790.61	\$8,491.12
Collections from Employees.....	7,878.73		7,878.73
	10,403.00		612.39
Due from Employees in January 1956	612.39		612.39
Net Society Cost.....	\$ 9,790.61	\$ 9,790.61	\$

Investments as set forth in Schedule 10 were confirmed in a letter to Mr. Roney from the Michigan National Bank, Grand Rapids, Michigan, dated December 28, 1956. We did not count these securities, nor was a confirmation letter sent to us directly from the bank.

Property and equipment are set forth in schedule 11. Office equipment is charged to expense when purchased and hence is not set forth as an asset of the society.

The distribution of such general expense items as office supplies, printing, telephone, repairs and equipment to the various society functions is very burdensome and time consuming to your accounting department. We suggest that Mr. Roney be authorized to charge these minor items to their respective expense category without attempting to distribute them to each small function.

Membership dues for the period were reconciled to paying members of 5,541. Of the 6,053 cards used we were able to account for 6,051.

The Annual Session and the Michigan Clinical Institute booth space income was verified by us and a spot check of JOURNAL Advertising was in agreement with your books of account.

Prior years 1% unallocated collection items due county societies were closed to miscellaneous income in an amount of \$1,398.35 upon our suggestion.

Net gain for all society functions for the year ended December 24, 1956, was \$40,060.31 as combined in Exhibit "C" of this report.

Respectfully submitted,
KNOTSMAN & SMITH
Certified Public Accountants

STATEMENT OF FINANCIAL CONDITION

December 24, 1956

ASSETS		
CASH ON HAND AND IN BANKS		
Michigan National Bank		
Lansing, Michigan	\$21,013.69	
Grand Rapids, Michigan		
(Treasurer's Account).....	8,713.01	
Office Cash (Lansing and Detroit, Michigan)	86.61	
		\$ 29,813.31
ACCOUNTS RECEIVABLE		
Advertising, Allowances and Other Items.....	\$22,913.71	
Collection Expense	15.50	
Due from Employees—Insurance Premiums.....	612.39	
Employee Advances.....	562.65	
	\$24,104.25	
LESS Allowance for Doubtful Accounts.....	126.30	
		23,977.95
INVESTMENTS (Schedule 10)		
(Market or Redemption Value—\$223,813.13)		229,793.25

JMSMS

REPORT OF KNOTSMAN & SMITH, CPA

PROPERTY AND EQUIPMENT

(Schedule 11)		
Land	\$10,000.00	
Office Building	\$34,500.00	
Lot Adjoining Office Building	6,000.00	
Building Improvements	5,664.06	
Building Equipment	3,836.09	
Parking Lot	1,913.60	
	51,913.75	
	\$61,913.75	
LESS Depreciation Allowance	8,634.55	53,279.20
OTHER ASSETS		
Prepaid Expenses		251.66
TOTAL ASSETS		\$337,097.37

LIABILITIES

ACCOUNTS PAYABLE		
Federal Unemployment Tax	\$ 206.42	
Michigan Unemployment Tax	48.35	
Unpaid Invoices	14,512.95	
Payroll Taxes—Payable	1,524.72	
		\$ 16,292.44
DEFERRED INCOME		
1957 MCI Booth Sales	\$13,650.00	
1957 Membership Dues	2,160.00	
		15,810.00
TOTAL LIABILITIES		\$ 32,102.44

SOCIETY EQUITIES

RESERVED FOR SPECIAL PURPOSES		
Public Education Reserve	\$37,245.00	
Public Education Program	73,891.87	
	\$131,136.87	
Public Service Account	3,675.16	
Professional Relations Account	4,897.50	
Rheumatic Fever Control Program	7,675.56	
Contingent Fund	53,614.34	
Building Fund	14,124.94	
TOTAL RESERVED	\$215,124.37	
General Society Equity		
12-24-55	77,593.98	
Net Gain for Period (Exhibit "B")	12,276.58	
		89,870.56
TOTAL EQUITIES (Exhibit "C")		\$304,994.93
TOTAL LIABILITIES AND EQUITIES		\$337,097.37

STATEMENT OF INCOME AND EXPENSE December 24, 1955, to December 24, 1956

INCOME		
Membership Dues	\$156,346.76	
Miscellaneous	1,456.35	
Interest Income (Schedule 10)	4,241.03	
Amortization (Schedule 10)	660.04	
		\$162,704.18
OTHER INCOME		
Annual Session (Schedule 2)	(2,468.88)	
Michigan Clinical Institute (Schedule 3)	(73.38)	
"The Journal" (Schedule 4)	1,096.70	
		(1,445.56)
TOTAL INCOME		\$161,258.62

EXPENSES

Administrative and General (Schedule 1)	\$85,160.42	
Society Activity (Schedule 1)	40,603.79	
Committee Expenses (Schedule 1)	23,217.83	
		148,982.04
NET GAIN		\$ 12,276.58

EXPENSES

December 24, 1955, to December 24, 1956

ADMINISTRATIVE AND GENERAL

Printing, Mailing and Postage	\$13,464.35
Office Supplies	3,574.33
Insurance and Fidelity Bonds	4,815.05
Auditing	750.00
Salaries—Administrative and Office	34,157.58
General Counsel Retainer and Expense	6,856.33
Equipment and Repairs	2,145.16
Telephone and Telegraph	5,046.92
Payroll Taxes	1,963.15
Miscellaneous Expense	2,598.74
Employee's Retirement Trust	9,790.61

TOTAL ADMINISTRATIVE AND

GENERAL EXPENSES	\$85,160.42
SOCIETY ACTIVITIES	
Council Expense	\$15,599.98
Delegates and Alternates to AMA	7,011.68
General Society Travel and Entertainment	7,501.61
Officers' Travel	5,558.78
Secretary's Letters	1,273.43
Woman's Auxiliary	600.00
Dues Collection Expense	3,058.31

TOTAL SOCIETY ACTIVITIES

EXPENSES	\$40,603.79
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COMMITTEE EXPENSE

Legislative	\$ 1,020.08
Postgraduate Medical Education	2,712.09
Preventive Medicine	102.11
Cancer Co-ordinating Committee	1,000.00
Child Welfare	431.71
Geriatrics	244.86
Industrial Health	90.93
Maternal Health	570.39
Civil Defense	204.50
Mental Health	507.85
Scientific Radio	724.00
Veneral Disease	38.49
Tuberculosis Control	50.49
Michigan Health Council	10,000.00
Rural Medical Service	211.24
Highway Accident Committee	460.70
Beaumont Memorial Restoration (Note 1)	2,353.56
Permanent Conference Committee	31.27
Sundry Committee Expense	2,463.56

TOTAL COMMITTEE EXPENSES

	\$23,217.83
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TOTAL EXPENSES (Exhibit "B")

	\$148,982.04
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Note 1:
This item is the net expense, after deducting \$6,920.00 of contributions received.

INCOME AND EXPENSE SUMMARY December 24, 1955, to December 24, 1956

	Balance 12-24-55	Income for the Period	Expenses for the Period	Net Gain or (Loss)	Balance 12-24-56
Equity—General Fund		\$162,704.18	\$148,982.04	\$13,722.14	
Annual Session		23,757.50	26,226.38	(2,468.88)	
Michigan Clinical Institute		13,360.00	13,433.38	(73.38)	
THE JOURNAL		94,400.27	93,303.57	1,096.70	
Contingent Fund	37,267.34	16,347.00	16,347.00		37,267.34
Building Fund	13,788.46	10,898.00	10,361.52	336.48	14,124.94
Public Education Reserve	30,000.00	27,245.00	27,245.00		53,614.34
Public Education Program	76,494.02	34,217.21	36,819.36	(2,602.15)	73,891.87
Public Service	281.28	19,071.51	15,677.63	3,393.88	3,675.16
Professional Relations	6,805.30	28,607.23	30,515.03	(1,907.80)	4,897.50
Rheumatic Fever Control Program	22,704.24	10,000.00	25,028.68	(15,028.68)	7,675.56
TOTAL	\$264,934.62	\$440,607.90	\$400,547.59	\$40,060.31	\$304,994.93

MAY, 1957

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REPORT OF KNOTSMAN & SMITH, CPA

INCOME AND EXPENSE OF THE ANNUAL SESSION

December 24, 1955, to December 24, 1956

INCOME	
Booth Sales—(99 spaces).....	\$23,757.50
EXPENSES	
Scientific Meeting.....	4,199.77
Registration and Hotel Expense.....	985.14
Exhibit Expense.....	3,804.27
State Society and Officers Night.....	3,253.73
Promotion—Printing, Mailing, Postage and Scientific Work Committee.....	3,840.85
Press Expense.....	2,652.95
Salaries.....	4,999.92
House of Delegates.....	1,365.66
Miscellaneous and Travel.....	1,124.09
TOTAL EXPENSES	\$26,226.38
LOSS ON ANNUAL SESSION	<u>\$(2,468.88)</u>

INCOME AND EXPENSE OF THE MICHIGAN CLINICAL INSTITUTE

December 24, 1955, to December 24, 1956

INCOME	
Booth Sales—(75 spaces).....	\$13,360.00
EXPENSES	
Scientific Meeting.....	2,146.77
Registration and Hotel.....	768.33
Exhibit Expense.....	3,335.48
Promotion—Printing, Mailing, Postage and Committee Meetings.....	3,654.05
Press Expense.....	1,692.92
Salaries.....	1,399.92
Residents and Interns Conference.....	39.76
Miscellaneous.....	196.15
TOTAL EXPENSES	\$13,433.38
(LOSS) ON MCI	<u>\$ (73.38)</u>

"THE JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY"

December 24, 1955, to December 24, 1956

INCOME	
Allocation from Dues.....	\$ 8,173.49
Subscriptions of Others.....	821.48
Advertising Sales.....	80,812.64
Reprint and Cut Sales.....	4,592.66
TOTAL INCOME	\$94,400.27
EXPENSES	
Editors Expense.....	\$ 3,000.00
Printing, Mailing and Postage.....	54,431.14
Reprint and Cut.....	3,508.22
Salaries.....	12,699.96
Discounts and Commissions.....	19,551.75
Miscellaneous.....	112.50
TOTAL EXPENSES	\$93,303.57
GAIN ON THE JOURNAL	<u>\$ 1,096.70</u>

INCOME AND EXPENSE OF THE BUILDING MAINTENANCE FUND

December 24, 1955, to December 24, 1956

INCOME	
Allocation from 1956 Dues.....	\$10,898.00
EXPENSES	
Maintenance—Utilities, Decorating, Supplies, Yard Work, etc.....	2,789.71
Janitor—Salary.....	1,814.99
Taxes, Property.....	815.65
Insurance.....	541.88
Depreciation.....	1,756.79
Reception Room Furnishings.....	111.72
Parking Area.....	658.48
Remodeling.....	2,072.30
TOTAL EXPENSES	\$10,561.52
GAIN ON BUILDING MAINTENANCE FUND	<u>\$ 336.48</u>

INCOME AND EXPENSE OF THE PUBLIC EDUCATION PROGRAM

December 24, 1955, to December 24, 1956

INCOME	
Allocation from Dues.....	\$34,056.26
Miscellaneous (Commissions).....	160.95
TOTAL INCOME (Note 1)	\$34,217.21
EXPENSES	
Committee Meetings.....	149.11
Equipment and Repairs.....	1,442.74
Printing, Mailing and Postage.....	3,796.46
Office Supplies.....	969.81
Salaries.....	14,554.50
Telephone and Telegraph.....	1,367.50
Travel and Entertainment.....	6,410.41
Publications, Pamphlets and Clippings.....	2,279.32
Radio, Television and Cinema.....	3,632.08
Miscellaneous.....	595.65
Exhibit Expense.....	1,621.78
TOTAL EXPENSES	\$36,819.36
LOSS DURING PERIOD	<u>\$(2,602.15)</u>

Note 1

This does not include \$27,245 allocation of dues specifically set aside for the Public Education Reserve.

INCOME AND EXPENSE OF THE PUBLIC SERVICE ACCOUNT

December 24, 1955, to December 24, 1956

INCOME	
Allocation from Dues.....	\$19,071.51
EXPENSES	
Salaries.....	\$12,285.10
Telephone and Telegraph.....	171.75
Rural Health Conference.....	258.72
Travel and Entertainment.....	2,962.06
TOTAL EXPENSES	\$15,677.63
GAIN DURING PERIOD	<u>\$ 3,393.88</u>

INCOME AND EXPENSE OF THE RHEUMATIC FEVER CONTROL PROGRAM

December 24, 1955, to December 24, 1956

INCOME	
Grant from Michigan Heart Association.....	\$10,000.00
EXPENSES (Central Office)	
Committee meetings.....	244.14
Equipment and Repairs.....	332.90
Payroll Taxes.....	1,826.02
Printing, Mailing and Postage.....	.....
Office Supplies.....	.....
Publications and Pamphlets (Purchased).....	.....
Salaries—Administrative and Office.....	11,600.07
Travel.....	900.30
Fellowships.....	2,875.00
Laboratory Aid Plan.....	.....
Telephone and Telegraph.....	.....
TOTAL CENTRAL OFFICE EXPENSES	\$17,778.43
CONTROL CENTERS	
Alpena.....	\$ 200.00
Ann Arbor.....	357.50
Bay City.....	780.00
Benton Harbor.....	165.00
Detroit.....	500.00
Grand Rapids and Muskegon.....	3,200.00
Jackson.....	.....
Kalamazoo.....	1,142.75
Lansing.....	.....
Petosky.....	.....
Pontiac and Royal Oak.....	37.00
Saginaw.....	.....
Sault Ste. Marie.....	.....
Traverse City.....	868.00
TOTAL CONTROL CENTERS	\$ 7,250.25
TOTAL EXPENSES	\$25,028.68
LOSS DURING PERIOD	<u>\$(15,028.68)</u>

REPORT OF KNOTSMAN & SMITH, CPA

INCOME AND EXPENSE OF THE PROFESSIONAL RELATIONS ACCOUNT

December 24, 1955, to December 24, 1956

INCOME	
Allocation from Dues.....	\$28,607.23
EXPENSES	
Rent to Wayne County Medical Society.....	\$ 480.00
Salaries	14,824.59
Telephone and Telegraph.....	764.22
Travel and Entertainment.....	5,710.87
National Meeting Expense.....	1,263.47
Public Relations—County Secretaries' Conference.....	6,225.04
County Society and Field Secretaries' Meetings.....	306.68
Woman's Auxiliary.....	940.16
TOTAL EXPENSES	\$30,513.03
LOSS DURING PERIOD	\$(1,907.80)

MSMS ANNUAL MEETING

September 25-26-27, 1957

Civic Auditorium, Pantlind Hotel

Grand Rapids

→ Make your hotel reservation now. ←

SECURITIES OWNED December 24, 1956

	Maturity Date	Face Value	Cost 12-24-55 (Book Value)	Redemption Prices 12-24-56	Purchases during Period	Amortization Debit or (Credit)	Cost 12-24-56 (Book Value)	Interest Paid on Purchase	Interest Received to Last Interest Date
UNITED STATES GOVERNMENT SECURITIES									
Savings Bonds—Series "G"	5-1-58	\$ 5,000.00	\$ 5,000.00	\$ 4,910.00	\$	\$	\$ 5,000.00	\$	\$ 125.00
Savings Bonds—Series "G"	3-1-60	5,000.00	5,000.00	4,850.00			5,000.00		125.00
Treasury Bond—Series "B" 2¾%	4-1-80/75	8,000.00	8,169.58	8,000.00		(8.92)	8,160.66		220.00
Savings Bonds—Series "K" 2.76%	6-1-66	45,000.00	45,000.00	43,875.00			45,000.00		1,242.00
Savings Bonds—Series "K" 2.76%	7-1-66	4,000.00	4,000.00	3,880.00			4,000.00		110.40
Treasury Bond—2½%	6-15-62/59	25,000.00		23,265.63	24,375.00	208.33	24,583.33	107.58	562.50
Treasury Bond—2½%	3-15-70/65	10,000.00	9,760.94	8,812.50		26.56	9,787.50		250.00
Treasury Bond—2½%	11-15-61	25,000.00		23,687.50	24,164.06	167.19	24,331.25	276.44	625.00
Treasury Bond—2½%	11-15-61	35,000.00		33,162.50	33,665.63	266.88	33,932.51	197.35	437.50
Time Certificate—Michigan National Bank, 2½%, Dated 3-16-55	Six months Notice Subject to Renewal	25,000.00	25,000.00	25,000.00			25,000.00		
Time Certificate—Michigan National Bank, 2½%, Dated 3-18-55	Six months Notice Subject to Renewal	15,000.00	15,000.00	15,000.00			15,000.00		375.00
BONDS HELD FOR PUBLIC EDUCATION PROGRAM									
Savings Bonds—Series "G"	8-1-58	30,000.00	30,000.00	29,370.00			30,000.00		750.00
		<u>\$232,000.00</u>	<u>\$146,930.52</u>	<u>\$223,813.13</u>	<u>\$82,204.69</u>	<u>\$660.04</u>	<u>\$229,795.25</u>	<u>\$381.37</u>	<u>\$4,822.40</u>

PROPERTY AND DEPRECIATION ALLOWANCE December 24, 1956

	Date Acquired	Cost	Depreciation Allowance Prior Years	Estimated Life (Years)	Depreciation Expense 1956	Depreciation Allowance 12-24-56
Land	1951	\$10,000.00	\$		\$	\$
Building	1951	34,500.00	5,050.00	30	1,150.00	6,200.00
		44,500.00	5,050.00		1,150.00	6,200.00
BUILDING IMPROVEMENTS						
New Building Entrance	1953	3,917.85	326.50	30	130.60	457.10
Remodel Basement and Storeroom	1956	1,746.21		30 (6 mos.)	29.10	29.10
		<u>\$ 5,664.06</u>	<u>\$ 326.50</u>		<u>\$ 159.70</u>	<u>\$ 486.20</u>
BUILDING EQUIPMENT						
Lighting	1952	\$ 2,121.50	\$ 565.72	15	\$ 141.43	\$ 707.15
Boiler	1952	1,714.59	457.14	15	114.30	571.44
		<u>3,836.09</u>	<u>1,022.86</u>		<u>255.73</u>	<u>1,278.59</u>
PARKING LOT	1953	1,913.60	478.40	10	191.36	669.76
LOT ADJOINING OFFICE BUILDING	1952	6,000.00				
		<u>\$61,913.75</u>	<u>\$6,877.76</u>		<u>\$1,756.79</u>	<u>\$8,634.55</u>

This is part of the report of The Council MSMS. See pages 364-376 in the March, 1957 number.

MAY, 1957

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Michigan Foundation for Medical and Health Education

PRESIDENT'S ANNUAL REPORT

By EARL INGRAM CARR, M.D.

Lansing, Michigan

Some added satisfaction can be conveyed by this twelfth annual report to the Members and Trustees of the Michigan Foundation for Medical and Health Education, Inc. Monetary advancement has occurred as will be indicated here and by later reports.

The Trustees are most happy to announce acceptance of appointment to the board by Mr. Howard C. Baldwin to fill the vacancy left by the death of our valued Trustee, Mr. C. Stewart Baxter. Mr. Baldwin is a distinguished lawyer, Trustee of the Kresge Foundation and director of various corporations and financial institutions. You will remember the part he played in the magnificent contribution of the Medical Research and Library Structure to the University of Michigan by the Kresge Foundation. Many of us attended the impressive ceremonies at the dedication.

The various activities and sponsorships, from year to year enumerated and reported, have been assumed through 1956. The business of the corporation has been faithfully conducted throughout the year and the officers and committees responded to needs and requests as they arose.

In THE JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY entitled "As the Physician Serves His Patient, So His Society Serves the Public," the story of the Foundation is told on pages 1326 and 1327 under the title "Organized Aid to Medical and Health Education." Reprints of this article are available at the secretary's office.

The Michigan Foundation Annual Lecture was delivered at the Clinical Institute in Detroit on March 7, 1956, by Doctor Alton Oschner of New Orleans on the subject of "What's New in Lung Cancer." The Biddle Annual Lecture was delivered in September by Lawrence A. Hafstad, Ph.D., of General Motors Corporation. His subject was "The Future of Atomic Energy and Medicine." Both lectures are financial responsibilities of the Foundation.

Processed, granted and advanced loans under the Revolving Fund Plan have aggregated to date \$15,263.00 to nine individuals. One loan in 1951 and a second loan to another student in 1953 have already been repaid in full making a return of \$3,100.00. In another instance \$1,500.00 remains not yet advanced. The outstanding loans at the moment rest at \$10,663.12.

The Rural Health Conference for 1956 was held last week on January 16, 17, and 18, at the Kellogg Center on the campus of Michigan State University. This three-day affair was generally regarded as one of the most successful with an attendance of at least 300. 168 attended the banquet and 24 presidents of various Michigan health organizations were present. Over 40 speakers and resource people participated. The program was divided by days, the first, Professional Day, the second, Rural Health Day, and the third, Community Health Day. The Michigan Foundation was credited as being the financial sponsor and there were 104 listed co-sponsors.

Gifts during 1956 exceeded \$11,000.00. \$2,313.12 was drawn upon the allocated \$6,000.00 for the Student Loan Fund by the Ingham County Medical Society. The balance of this allocation earned \$72.19 in interest making the total balance \$3,759.07 to be utilized under the terms of the gift. Setting an example for other county medical societies, the Barry County Medical Society donated and delivered \$5,000.00 this year. They stipulate that it be used for residents of their county who need supplemental financial aid as medical students under the Foundation Student Aid Revolving Fund Plan. No applicants under this gift have yet appeared. Appreciation of this generosity has been expressed by the trustees by special communication and by editorial in THE JOURNAL of the State Society. Contributions of \$1,000.00 each have been received from the Women's Auxiliary of the Wayne County Medical Society and from the estate of the late Henry A. Luce, M.D. Other contributions under the LeFevre Birthday Plan and otherwise, aggregate for the year \$2,360.00. Our investment portfolio yielded for the year \$3,543.84 in interest and dividends.

The auditors show total reserves of \$127,332.90 besides redemption value increase of \$5,431.11 and the balance of allocation by Ingham County Medical Society of \$3,759.07 makes a total of \$136,523.08 as a net worth of the Foundation on the audit date.

Increase of diversity and number of activities by the Foundation depends upon money. General acceptance of the LeFevre Birthday Plan would make regular annual income. Remember the Foundation on your birthday, just before or just after your health audit.

January 23, 1957.

REPORT OF THE SECRETARY

By WM. J. BURNS, LL.B.

Lansing, Michigan

The Secretary has executed the duties of his office according to the By-Laws and as provided in Roberts Rules of Order, pursuant to the instructions of the

Board of Trustees and with the helpful guidance of President Carr.

On January 24, 1956, the Woman's Auxiliary to the

MICHIGAN FOUNDATION FOR MEDICAL AND HEALTH EDUCATION

Wayne County Medical Society contributed \$1,000.00 to the Student Loan Revolving Fund, with certain specifications attached to the gift which were noted by the Foundation's Board of Trustees, January 25, 1956.

On February 4, 1956, the late Henry A. Luce, M.D., devised \$1,000.00 to the Foundation, the gift containing a special earmarking purpose: for research into physical causes of mental illness.

On November 1, 1956, the Barry County Medical Society contributed \$5,000.00 to the Foundation, earmarked for purpose of loans to medical students, residents of Barry County.

The Michigan Foundation for Medical and Health Education Lecture, to be given at the 1957 Michigan Clinical Institute—with the speakers' expenses to be paid out of the Biddle Fund to the Foundation—will be presented March 13 by Charles B. Huggins, M.D., of Chicago who will speak on the "Control of Human Cancers by Endocrinologic Methods."

The Student Loan Fund has been utilized to aid the medical education of the following medical students:

Robert E. Pearson.....	Wayne State University
Robert O. Webster.....	University of Michigan
Al Edmond Eary, Jr.....	University of Michigan
Benjamin J. Koepke.....	Wayne State University
Donald P. Jackson.....	Wayne State University
John C. Shelton.....	University of Michigan
Russell F. Smith.....	University of Michigan
Paul C. Linnell.....	University of Michigan
Richard Morin.....	University of Michigan

January 23, 1957

CHRONIC DISEASE—A CHALLENGE TO THE MEDICAL PROFESSION

(Continued from Page 618)

each specialist working more or less independently needs objective scrutiny—and such modification as may be necessary.

Conclusion

A number of hardy pioneers have already attacked the medical frontier of chronic disease. Each day brings further progress. All segments of American medicine are called upon to push forward in developing new scientific knowledge and to fully utilize existing knowledge in meeting today's chronic disease problems. Many of these can be prevented. The effect of others can be minimized, or the condition arrested.

In moving toward these goals, it would profit

us well, I think, to consider Dr. Franklin Murphy's⁴ good advice. He reminds us that:

"These problems have many facets, scientific, economic, and social, and will tax our greatest combined efforts. They will require imagination and objectivity for their solution. New paths must be blazed (as indeed is the case in many other aspects of our culture today). Their effective resolution will be hastened as we blend public and private effort on the basis of logic and need."

References

1. Hess, Elmer, M.D.: Address of president before the house of delegates at the annual meeting of the American Medical Association in Chicago, Illinois, June 11, 1956. *J.A.M.A.*, 161:734-738 (June 23) 1956.
2. Homburger, F.: The medical care of the aged and chronically ill. Boston: Little, Brown and Company, 1955.
3. Kurlander, A. B.: Preventive aspects of chronic disease. *J. Nat. M. A.*, 48: March, 1956.
4. Murphy, F. D.: Health—Public or Private? *Am. J. Pub. Health*, 46:15-18 (January) 1956.

CHRONIC DISEASE—A CHALLENGE TO PUBLIC HEALTH

(Continued from Page 622)

Conclusion

Many health departments have not yet faced up to their unmistakable responsibility or concentrated their full potential in the chronic disease field. In public health, as in any other important activity, we must address our efforts to problems as they are—not as we should like to see them. This leaves us no choice. The chronic illness problem is of such magnitude and complexity that no one group, no one profession can hope to solve it alone. We must assure a co-ordinated effort of the necessary groups and disciplines if we are to achieve success.

The ideal response to this challenge has been described as "unity of services." Preventive, curative, and restorative programs—both public and private—must be combined to accomplish that "unity."

We have, as a nation, concentrated our resources in a commendable fashion on the problems of youth and youth's environment. The job ahead in the health field is to effect a comparable concentration on the problems that generally manifest themselves in adult life.

Michigan's Department of Health

Albert E. Heustis, M.D., Commissioner

NEW BIRTH, DEATH RECORDS SET

Provisional vital statistics for 1956, compiled in the state health department, show six new records set in Michigan.

The state's birth rate reached an all-time high of 27.4, slightly over the previous record rate of 27.3 established in 1954. Births totaled 205,650, exceeding the 200,000 mark for the first time in the state's history. The 100,000 mark was passed in 1941.

The death rate of 8.5 in 1956 was an all-time low, though only a slight gain over the 8.6 of 1954.

The vital index, the birth-death ratio, reached 320 in 1956. The previous high was 316, recorded in 1954.

The infant death rate stood at 24.6, an all-time low. This was a slight gain over the 24.8 recorded in 1955 but still high for a state like Michigan.

The state's population totaled 7,516,000 in 1956, a gain of 1,144,234, or 18 per cent over the 1950 figure. This makes Michigan the fastest growing state in the Midwest.

Provisional 1956 figures for the United States include: birth rate, 29.9; death rate, 9.4; vital index, 266; and infant death rate, 26.1.

NEW HOSPITAL MANUAL IN PREPARATION

First draft of a manual to be used as a companion to the Michigan Department of Health publication, "Rules and Minimum Standards for Hospitals," has recently been completed by staff members. It is designed to clarify some of the rules and to suggest acceptable procedures for patient care, especially in the maternity department.

The preliminary draft of the manual is being reviewed by a number of physicians, nurses and hospital administrators and the detailed and thoughtful suggestions that are coming to the Commissioner from this busy group are greatly appreciated. It is the same type of helpful advice that was given the department when it was developing rules and standards after being given responsibility in hospital licensing in 1951.

It will be several months before the manual is ready for distribution.

OCCUPATIONAL HEALTH ENGINEERS AID INVESTIGATION

Department occupational health engineers, working with plant engineers and representatives of management and labor, took an active part in investigating the recent paint solvent explosion in the frame painting building of an automobile manufacturing plant. In the explosion, some twenty-two workmen were injured and four have died.

Immediate plans for rebuilding the frame painting area were drawn up by plant engineers. These plans

were discussed in detail at several conferences and new safety features proposed were examined thoroughly by department engineers. As one checking procedure a pilot production run was made to determine whether design specifications were being met. On the basis of results, additional improvements were suggested and put into effect.

At a meeting between department and plant engineers, state and municipal officials and company and union representatives, results were reviewed and additional investigative procedures outlined.

At a final meeting, department engineers reported that it was their opinion that the company had installed a greatly improved system so far as safety was concerned and that within the limits of the present method of frame painting, everything within reason and good practice had been installed. It was emphasized that there is no industrial painting operation of a similar nature that is 100 per cent explosion proof and that this makes of first importance the installation and maintenance of measures and precautions that prevent injury to the workers in the event of an explosion.

DEPARTMENT MOVES INTO NEW ADDITION

The division of engineering and two sections of the division of disease control, records and statistics are now occupying their new quarters in the department's recently completed addition. The new two-story building adjoins the Administration Building on the south.

BABY SITTER HANDBOOK AVAILABLE

A recent publication that is much in demand from the department is a 30-page booklet entitled "Baby Sitting." The material was prepared by a sub-committee of the Interdepartmental Staff on Children and Youth. The booklet emphasizes the responsibilities of the sitter to the family and the family to the sitter, discussing safety precautions, understanding the behavior and needs of children at different age levels, and ways to help children to play happily. The content is sufficiently detailed to serve the needs of the many courses that are now being given in junior and senior high schools for the training of boys and girls in baby sitting.

Copies of the booklet are available upon request.

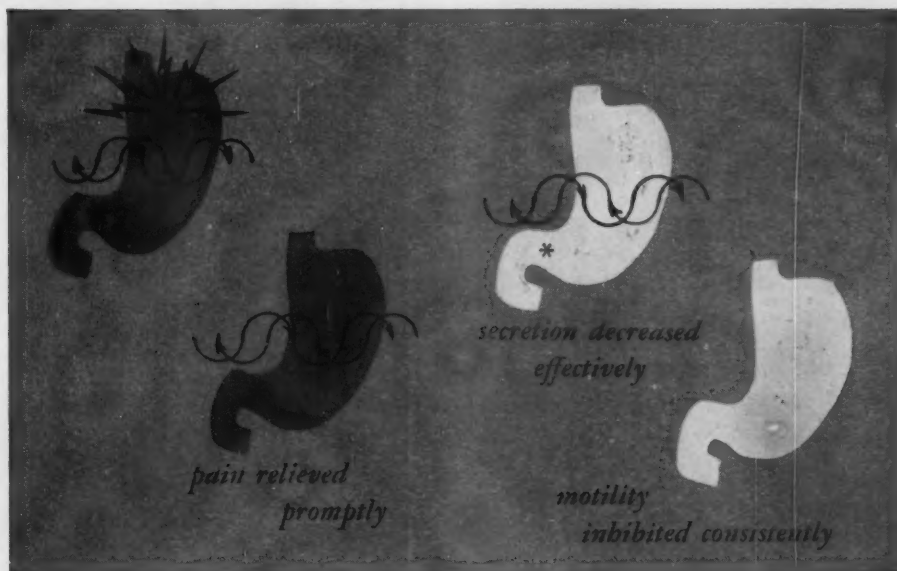
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* * *

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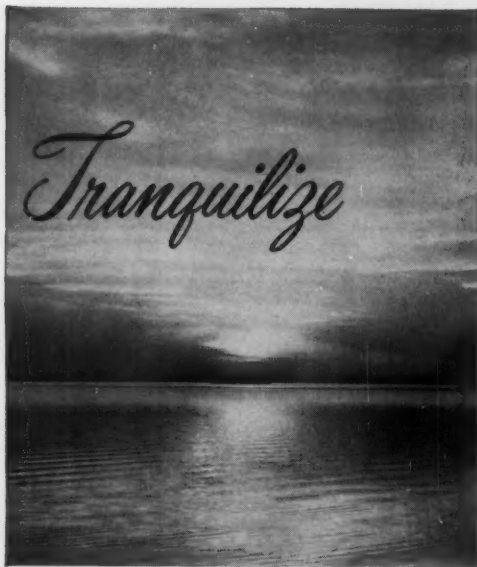
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*Lichstein, J.; Morehouse, M. G., and Osmon, K. L.: Pro-Banthine in the Treatment of Peptic Ulcer. A Clinical Evaluation with Gastric Secretory, Motility and Gastroscopic Studies. Report of 60 cases, Am. J. M. Sc. 232:156 (Aug.) 1956.

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In Memoriam

Eugene V. Gourley, M.D., forty-four, Detroit practitioner for eleven years and staff physician at Mt. Carmel Mercy Hospital. Born in Mexico, he was a graduate of the University of Detroit and Wayne State University College of Medicine, and had interned at Grace Hospital. Dr. Gourley served in the Army Medical Corps during World War II, attaining the rank of lieutenant colonel. He was a member of the Wayne County Medical Society. He died suddenly in his office March 8, 1957, of a heart attack.

* * *

James W. MacMeekin, M.D., forty-nine, prominent Saginaw surgeon and chief of staff of Saginaw General Hospital. A native of Saginaw and son of a Saginaw doctor, he graduated from the University of Michigan Medical School. During World War II he served as a Navy doctor with the rank of lieutenant commander. Doctor MacMeekin was an amateur pilot of about 15 years' experience. He was a member of the Saginaw County Medical Society. He died March 16, 1957, when his private plane crashed.

* * *

Sylvester J. O'Connor, M.D., thirty-nine, Ann Arbor surgeon and Associate Professor of Surgery at the University of Michigan Medical School. Born in Burbank, South Dakota, he received his Bachelor of Science degree from Trinity College, Sioux City, Iowa, and was graduated from the University of Michigan Medical School in 1942. During World War II, he was associated with the Army Medical Corps, stationed at University Hospital. He was a member of the Washtenaw County Medical Society. He died suddenly March 10, 1957.

* * *

David H. O'Donnell, M.D., eighty-seven, Detroit practitioner for sixty-six years and physician to many prominent Detroit families. Born in Wardsville, Ontario, he graduated from the Detroit College of Medicine in 1891. During his career, Doctor O'Donnell delivered more than 7,000 babies, among them the late Edsel B. Ford. Organizer of Providence Hospital in 1908, he later was chief of staff of the hospital for thirteen years. He was also medical director of St. Joseph's Retreat, Dearborn, for thirty years. He was a member of the Wayne County Medical Society and an Emeritus Member of the Michigan State Medical Society. He died March 18, 1957.

* * *

Frederick W. Palmer, M.D., fifty, superintendent of the Mt. Pleasant State Home and Training School since 1949. Born in Yale, Michigan, he received his M.D. degree from the University of Michigan. He was a member of the Gratiot-Isabelle-Clare County Medical Society. He died suddenly March 23, 1957.

* * *

Melvin D. Roberts, M.D., seventy-seven, Hancock general practitioner for fifty-three years. Born in Char-

(Continued on Page 644)



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Melvin D. Roberts, M.D.

(Continued from Page 642)

lotte, Michigan, he graduated from the University of Michigan Department of Medicine and Surgery in 1903. He did military service in both World War I and World War II, retiring to civilian life in 1945 with the rank of Commander. He was a member of the Houghton-Baraga-Keweenaw County Medical Society and a Life Member of the Michigan State Medical Society. He died March 8, 1957, after a long illness.

* * *

George W. Robinson, seventy-nine, Detroit obstetrician for fifty years. Born in Bradford, Ontario, he was graduated from the Detroit College of Medicine in 1905. He had been a consultant staff member at Detroit Memorial Hospital before his retirement in 1948. He was a member of the Wayne County Medical Society, and a Life Member of the Michigan State Medical Society. He died March 10, 1957.

* * *

Joseph Burgess Whinery, M.D., ninety, of Winter Park, Florida, former Grand Rapids practitioner for fifty-seven years and father of State Representative Thomas J. Whinery. Born in Wilmington, Ohio, he graduated from the University of Michigan Medical School in 1892. During World War I, he served as a major in the Army Medical Corps. He was a member of the Kent County Medical Society and an Emeritus Member of the Michigan State Medical Society. He died March 21, 1957.

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645



NEWS MEDICAL

MICHIGAN AUTHORS

M. K. Newman, M.D., Detroit, is the author of an article, entitled "Diagnosis, Management, and Problems of Muscular Dystrophy," published in the Detroit District of the *Michigan State Nurses Association Journal*, March, 1957.

Charles S. Stevenson, M.D., Harold A. Ott, M.D., Palmer E. Sutton, M.D., and Mary Lou Bard, M.D., Detroit, are the authors of an article, entitled "Maternal Deaths from Obstetric Anesthesia and Analgesia: Can They Be Eliminated?" published in *Obstetrics and Gynecology* and condensed in *American Practitioner and Digest of Treatment*, February, 1957.

Carl T. Javert, M.D., New York, is the author of an article, entitled "Program of Therapy for Repeated Abortion Patients," published in *THE JOURNAL* of the Michigan State Medical Society, July, 1955, and condensed in the *American Practitioner and Digest of Treatment*, February, 1957.

Leon S. McGoogan, M.D., Omaha, is the author of an article, entitled "Endometriosis," published in *THE JOURNAL* of the Michigan State Medical Society, July, 1955, and condensed in *American Practitioner and Digest of Treatment*, February, 1957.

Robert E. L. Berry, M.D., F.A.C.S., and William Rottschaefer, M.D., Ann Arbor, are the authors of an article, entitled "The Lymphatic Spread of Cancer of the Stomach Observed in Operative Specimens Removed by Radical Surgery Including Total Pancreatectomy," published in the *Journal of Surgery, Gynecology and Obstetrics*, March, 1957.

Seward E. Miller, M.D., Ann Arbor, is the author of an article, entitled "Medical Aspects of Radiological Health," presented in part at the Ninth Health Conference for Business and Industry in Houston, September, 1956, and published in *Industrial Medicine and Surgery*, March, 1957.

Mathew Alpern, Ph.D., Ann Arbor, is the author of an article, entitled "The Position of the Eyes During Prism Vergence," published in *A.M.A. Archives of Ophthalmology*, March, 1957.

J. Reimer Wolter, M.D., Robert L. Goldsmith, M.D., Ann Arbor, and Roland L. Phillips, M.D., Eloise, are the authors of an article, entitled "Histopathology of the Star-Figure of the Macular Area in Diabetic and Angiopathic Retinopathy," published in *A.M.A. Archives of Ophthalmology*, March, 1957.

Irving Shapiro, M.D., Minneapolis, Clifford W. Gurney, M.D., and Arthur J. Solari, M.S., Ann Arbor, are the authors of an article, entitled "Radioiodine Content of Aqueous, Vitreous, and Lens," published in *A.M.A. Archives of Ophthalmology*, March, 1957.

Carl F. List, M.D., Grand Rapids, is the author of an article, entitled "Disturbances of Eye Movements as a Neurologic Problem," published in the *New England Journal of Medicine*, March 8, 1956, and reprinted in *Guldract*, February, 1957.

R. S. Knighton, M.D., and J. D. Fox, M.D., Detroit, are authors of an original article, "Diagnosis and Treatment of Eosinophilic Granuloma of Skull," which appeared in *JAMA* December 1, 1956, page 1294.

J. P. Ferguson, M.D., V. Z. Linn, M.D., J. A. Sheets, Jr., M.D., and M. M. Nickels, M.D., Traverse City, are authors of an original article, "Methylenedate (Ritalin) Hydrochloride Parenteral Solution," which appeared in *JAMA* of December 1, 1956, page 1303.

* * *

Three new employees have been added to the AMA headquarters staff in Chicago. Two of them—John Guy Miller of Louisville and Joseph Miller of Lexington, Kentucky—joined the staff of the Council on Medical Service on April 1. They will be members of what is commonly known at headquarters as a "research task force" which will be established to handle special projects for the Council's eight different committees. It is planned to have three or four members on this force, who will work on such specific assignments as Hill-Burton, the new disability program under Social Security, the relationship of private physicians to physicians in public health, and other projects.

John Guy Miller has been serving as field representative for the Kentucky State Medical Association since 1952; prior to that job, he served in a similar capacity with the Michigan State Medical Society.

* * *

Physical Medicine and Rehabilitation.—Highland View Hospital, Cleveland, Ohio, in affiliation with Western Reserve University, is offering a six-month post-graduate Course in Physical Medicine and Rehabilitation. The Course will be from July 1 to December 31, 1957. Its purpose is to provide didactic and applicatory training in the principles and practices of Physical Medicine and Rehabilitation, with particular emphasis on chronic illness. The course is designed primarily to enhance the proper practice of rehabilitation methods by allied specialists. Fellowships are available for this course from the Office of Vocational Rehabilitation, Department of Health, Education and Welfare. Application should be made to Highland View Hospital, Cleveland 22, Ohio.

(Continued on Page 648)

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(Continued from Page 646)

Harry M. Nelson, M.D., Detroit, Chairman of the Michigan Cancer Coordinating Committee, was guest speaker at the Cancer Forum sponsored by A. C. of S., Georgia Division, in Atlanta on March 15. Dr. Nelson's topic was "Value of Routine Vaginal Smears and Proctoscopies in Cancer Detection."

* * *

The Sixth Annual Symposium for General Practitioners on Tuberculosis and Other Chronic Pulmonary Diseases will be held at Saranac Lake, New York, July 8-12, 1957. For information on this Symposium, sponsored by the American Trudeau Society, et al., write Henry W. Leetch, M.D., General Chairman, P.O. Box 11, Saranac Lake, New York.

* * *

Fear: "A Doctor does not know from one day to the next whether or not he will be on the rounds at the hospital or under the boot of the political police in jail," comments Laszlo Kovasci, M.D., a Hungarian refugee in Ann Arbor. "Doctors can be fired in one minute on the charge of being 'against the state.' This usually happens whenever a qualified, reliable Communist Party member is available to replace him." Dr. Kovasci says that medicine has suffered greatly under Communist domination.

* * *

Undergraduate scholarships worth \$50,000 have been established by the Upjohn Company of Kalamazoo for the 1957-58 school year, including six for students who plan to major in pre-medicine, pharmacy, engineering, or any of the chemical or biological sciences. For information, write the Upjohn Company.

* * *

Did you know that babies are being born at a rate of 480 an hour—11,520 a day—4,205,000 a year?

Did you know that deaths are occurring at a rate of 171 an hour, 4,104 a day, and 1,498,000 a year?

Did you know that the net population increase of the United States (including immigration) is 336 an hour, 8,064 a day or 2,900,000 a year.

Did you know that since 1950 our population has increased by 17,627,000—more than equivalent to the population of Canada? Our U. S. population by 1975 (less than twenty years from now) will increase to 220,800,000—an increase of 31.2 per cent.

* * *

Construction of a \$1,500,000 College of Nursing building at Wayne State University, Detroit, will begin in September, 1957, and will be ready for occupancy in early 1960.

* * *

Construction of a new Children's Hospital within the University of Michigan Medical Center will give Michigan its first complete children's center providing total care, including psychiatric, for the child, according to a University of Michigan release which indicated that the new 200-bed hospital will be constructed adjacent to the existing 75-bed Children's Psychiatric Unit opened in December, 1955.

Current information on tuberculosis indicates that there are somewhat less than 400,000 active tuberculosis cases in the United States at any one time, approximately one-third of which are hospitalized for tuberculosis, one-third are known cases at home, and one-third are undetected cases.—ROBERT J. ANDERSON, M.D., *Public Health Reports*, February, 1956.

Sidney Friedlaender, M.D., Detroit, Michigan, was one of the participants in the Panel discussions on "Present Concept of Therapy in Allergy with Cortisone and Allied Drugs" and "Drug Sensitivities," sponsored by the Honolulu County Medical Society, at Honolulu, Hawaii, on February 15, 1957.

Upper Peninsula Medical Society members and their wives will convene on June 21 and 22 at Houghton, in the heart of the Copper Country's beautiful vacation land. Committees have been appointed by T. P. Wickliffe, M.D., President of the Society, and plans are well under way to make this sixty-fourth session an outstanding success, both from the scientific and social standpoint.

The Copper Country offers some of the country's most beautiful scenery and a wide variety of vacation activities. Doctors of the Lower Peninsula are urged to mark the dates, and are cordially invited to attend the meeting and enjoy a vacation. Information may be secured by writing to Secretary F. W. Larson, M.D., Houghton.

The Seventh American Congress on Maternal Care (formerly known as the American Congress on Obstetrics and Gynecology) is scheduled for the Palmer House, Chicago, July 8-12, 1957. The five-day Congress will present topics dealing with the interprofessional approach to maternal and infant care. For information, write the American Committee on Maternal Welfare, 116 South Michigan Avenue, Chicago 3, Illinois.

The United States Atomic Energy Commission has announced the awarding of forty-eight unclassified life science research contracts in the fields of medicine, biology, biophysics, and radiation instrumentation, as part of the AEC's continuing policy of assisting and fostering research and development in the fields related to atomic energy. Among these awards is one to the University of Michigan for the "Clinical Evaluation of Teletherapy," the investigators being F. J. Hodges, M.D., and Isadore Lampe, M.D.

Home Town Care Program. On March 12, 1957, the Central Office of the Veterans Administration reversed its position in regard to the proposed cancellation of the Home Town Care Program for veterans utilizing such intermediaries as Blue Shield. The states involved in this problem were North Carolina, Wisconsin, South Dakota, Colorado, Oregon, Washington, California, the Territory of Hawaii and Michigan. Dr. William Bromme had been named as spokesman for the group. Mr. L. Gordon Goodrich was present,

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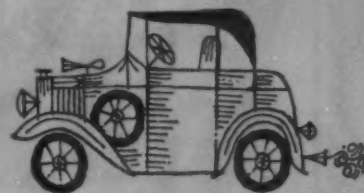
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It was agreed that the uniform contract developed by the representatives of these medical areas, which is, in effect, the program as it has operated in Michigan for over a decade, would be the standard uniform agreement for this type of program; and that the reporting forms as presently used in Michigan, would become the official reporting forms in this program. It was the opinion of those present that when the Veterans Administration initiates the long term program these same forms might be easily adapted for the purposes of the new program. Certain items of administrative expense, which in the past have been borne by the intermediary, such as Michigan State Medical Service, would now be taken care of by Veterans Administration. An example of this is the printing and distribution of the forms involved, the cost of which the Veterans Administration is assuming. *Detroit Medical News*, March 23, 1957.

* * *

University of Michigan Regional Conference on Hypertension will take place in Ann Arbor, Michigan, June 7-8, 1957, in recognition of twenty-fifth anniversary of the first production of Experimental Renal Hypertension by Dr. Harry Goldblatt. Reports will be presented on the Basic Mechanisms of Renal Hypertension, including adrenal, neurogenic and renoprival aspects. Overseas participants will include, among others, Dr. Eduardo Braun-Menendez from Argentina, and Drs. Goldblatt, Helmer, Wakerlin, Skeggs, Kohlstaedt, Page, Kejdi and McCubbin from the Michigan regional area. Those desiring to attend are urged to write well in advance for information and reservations to Dr. John Sheldon, Director, Department of Postgraduate Medicine, University of Michigan Medical School, University Hospital, Ann Arbor, Michigan.

* * *

Malaria Control.—The solution of the international public health problem of highest priority in the Americas was advanced one step forward by a special contribution of \$1,500,000, made by the United States Government to increase the special fund of the Pan American Sanitary Organization for malaria eradication.

Each year, some 250,000,000 persons are afflicted with this disease throughout the world, approximately 2,500,000 dying of it annually. Here in the Americas there are still extensive malarious areas and there are only a few countries where it is non-existent or has been eradicated. Malaria has been eradicated from the United States, for instance, in only the past three years.

* * *

Civil Aeronautics.—A new order makes medical certification of private pilots a more exclusive procedure. Until now, any physician, even at times a chiropractor could give the examinations. The new rule requires that examinations be given only by Civil Aeronautics Administration designated examiners, of whom there are 1,800 in the land. There has been some delay, but the rule should be in effect when this appears.

NEWS MEDICAL

A new bill in the House of Representatives would authorize Walter Reed Army Institute of Research to award Master's and Doctor's degrees, but it is being delayed because of objection that the government should leave awarding of degrees to the authorized educational institutions.

The National Fund for Medical Education, being a federally Congressional organization, makes a yearly financial report. Grants to medical schools in 1956 totaled \$3,066,079, compared with \$2,657,434 in 1955. Administrative expenses were \$469,412, of which \$230,079 covered salaries.

The Hill-Burton hospital program is now in its eleventh year. To date, 3,332 projects have been approved, at a total estimated cost of \$2,712,512,871, with 754 under construction. The total is 146,947 hospital beds and 818 health centers.

M. K. Newman, M.D., Detroit, spoke before the Factfinders Club, Tuller Hotel, February 26, 1957, on "The Total Concept of Rehabilitation." For the Staff of Physical Medicine and Rehabilitation, University of Michigan, he presented a talk, entitled "Practical Aspects of Physical Medicine and Rehabilitation." On March 8, he presented a paper at the annual meeting of the Greater New York Chapter of the American Physical Therapy Association at the New York Coli-

seum. His subject was "Physical Medicine and Rehabilitation in Geriatrics." On March 22, he gave a medical talk to the staff of physical medicine and rehabilitation at the University of Illinois College of Medicine, entitled "Rehabilitation Techniques in the Management of Muscular Atrophy."

Lewis Cohen, M.D., presented a paper entitled "Electrovasography in the Study of Peripheral Vascular Dynamics" at the National Biophysics Conference in Columbus, Ohio, on March 5, 1957.

The American College of Surgeons held a Sectional Meeting at the Royal York Hotel, Toronto, Ontario, on March 25, 26, and 27, 1957. Michigan men participating in the program were Laurence S. Fallis, M.D., F.A.C.S., and Conrad R. Lam, M.D., F.A.C.S., Detroit; Richard H. Meade, M.D., F.A.C.S., Grand Rapids; F. Bruce Fralick, M.D., F.A.C.S., Ann Arbor; Reed M. Nesbit, M.D., F.A.C.S., Ann Arbor; D. Emerick Szilagyi, M.D., F.A.C.S., Detroit. Serving on the Board of Regents are Reed M. Nesbit, M.D., Ann Arbor, and Grover Penberthy, M.D., Detroit. Frederick A. Collier, M.D., Ann Arbor, serves on the Advisory Council.

Auto Makers Urged to Work for Safety.—Manufacturers are the only ones who can incorporate safety measures into autos, and if they don't do so Congress should act to force them. This in essence was the



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1. Pollock, B. E., and Pruitt, F. W.: *Am. J. M. Sc.*, 226:172, 1953.

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testimony of a representative of the Michigan State Medical Society, appearing before the special safety subcommittee of the House Interstate and Foreign Commerce Committee. John D. Rogers, M.D., Bellaire, the Michigan witness, also cited a recommendation of the A.M.A. House of Delegates, adopted December, 1955, which urged Congress to authorize a national body to approve and regulate auto safety standards.—*AMA Washington Letter*, March 29, 1957.

* * *



General hospital admission x-rays in Michigan led to the discovery of 500 previously unknown active cases of tuberculosis in 1955, the latest year for which figures are available.

Not quite half of the admissions for the fifty-five general hospitals reporting routine chest x-ray programs were screened. Less than one-third of all general hospital admissions were x-rayed in Michigan.

The 1955 record suggests that there may be 1,000 or more unsuspected active cases of tuberculosis among the unscreened portion of hospital admissions.

MICHIGAN TUBERCULOSIS ASSOCIATION

* * *

Wayne State University's Board of Governors, at a recent monthly meeting, reviewed gifts and grants totaling \$85,850 accepted by the University.

Major grants went to the instructional and research programs of the College of Medicine, including \$42,286 from the National Fund for Medical Education and the American Medical Education Foundation.

Scholarship and fellowship contributions totaled \$5,902. The Ford Motor Company gave \$5,000 and Burroughs Foundation \$1,500 to the Materials Management Center.

* * *

Army hospitals in this country and overseas will welcome 164 graduates from seventy-one approved medical schools as interns for the year beginning July 1. The interns represent all sections of the United States and were selected by the Army Medical Service in participation with the sixth National Intern Matching Program. This is the largest number of medical interns to be admitted at one time by the Army Medical Service. Reflecting the national trend towards earlier marriage and larger families, 73 per cent (121) of the interns are married. Of this group, over half have children: thirty-three having one child, twenty-one having two children, four having three children and two having four children. The remaining sixty married interns have none.

* * *

Columbia University has announced the establishment of two postgraduate-level, correspondence-type courses for hospital executives in eastern Hospital Assemblies. The courses will focus on the problems of small and medium-sized hospitals and will aim at giving

JMSMS

NEWS MEDICAL

people active in the field an opportunity for systematic study of hospital organization and management. Funds for the program will be supplied by the Kellogg Foundation. Harold Baumgarten, Jr., former manager of Hospital Relations of the Blue Cross Commission, has been appointed program director.—*Hospitals*, February, 1957.

Erythropoetin.—University of Chicago medical scientists reported March 23, 1957, that they have established the mechanism and site of production of a new hormone which controls red blood cell formation. The hormone is produced in response to the changing balance between the oxygen demand and supply of the body. The process is analogous to the mechanism by which the level of blood sugar regulates the production of insulin. Leon C. Jacobson, M.D., and three of his research team made the announcement. The hormone, erythropoetin, is produced by the kidneys and is found in normal blood of human beings and animals. It stimulates the bone marrow to make the red cells. Though it has not yet been chemically isolated, it has been concentrated in blood serum by 100 to 1000 times its normal amount.

Social Security Extensions.—Health, Education, and Welfare reports show that more than one-half of the country's clergymen have exercised their option and are covered by social security. The deadline was April 15, 1957.

Members of Congress are still receiving letters and

petitions from individuals and groups requesting Social Security for M.D.s.

Medical Budgets.—Congressional hearings just published on the HEW Department's budget, covering 1602 pages, gives the administration's views of health insurance; research in the 100-bed clinical center at Bethesda, Md.; comments on medical school subsidization, Indian care, and U. S. Public Health Service. It is an encyclopedia.

Hoxsey Counter-attack.—Much attention was given at the hearing to the Hoxsey Cancer Clinic's counter-offensive against FDA. Since the latter had posters warning the public against Hoxsey treatment placed in 46,000 post offices and substations, the Texas promoter came back with a petition write-in campaign calling for Congressional investigation of FDA. Larrick attributed the campaign to Gerald B. Winrod, of Wichita, Kansas, as "a paid propagandist for Harry M. Hoxsey."

On Friday evening, March 15, 1957, while driving home, the Editor heard a radio program "Sound Off," on which several persons asked whether anyone could give the address of the Hoxsey cancer treatment. There were at least half a dozen answers.

Plans for construction of a two-story addition to the Henry Ford Hospital have been announced by Benson Ford, President of the Board. The contract is signed

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and construction will begin immediately. The addition will be atop the present front of the building and will become the fifth and sixth floors of the main building. There will be about 100,000 square feet of floor space and about 150 beds, raising the hospital's capacity to 950.

The original Ford Hospital was started in 1913, and was opened to the public in 1915. The present front was opened in 1920-1921, and the new clinic building in February, 1955.

* * *

Social Security Deadline Extended.—Ranking members of the House of Representative Ways and Means Committee are sponsoring a bill (H.R. 6191) to extend for one year the deadline for disabled workers to apply for determination of disability preliminary to "freezing" of their benefit rights, now June 30, 1957. HEW believes this will make an additional 165,000 workers eligible.

* * *

Hospitalization for the Aged.—There has been much consideration of hospitalization for the aged for quite some time, but the AFL-CIO Executive Council has announced its support, and the measure is again reactivated. The plan started in 1951 under our old acquaintance, Oscar Ewing, and has been reintroduced each term. The program is the same, to give up to sixty days of each year of hospitalization for persons over sixty-five on OASI. The government would pay the

costs out of the Old Age and Survivors Trust Fund. The worker's dependents over sixty-five would also be eligible.

* * *

Army Medical Officers.—Elsewhere in this issue the assignment of 160 new medical interns and residents to army hospitals is reported. Occasionally announcements of opportunities for younger men to apply for Army Service have also been published. There are about five applications for each vacancy. We have always been of the opinion high ranking officers were few in the Army Medical Corps, but upon inquiry find there are eleven Major Generals, and twenty-one Brigadier Generals. There have never been any Lieutenant Generals, and we believe there should be—at least to carry an equal rank with many installations. The Senate, on March 25, 1957, approved three new Brigadier Generals.

* * *

The total membership in Blue Cross Plans as of December 31, 1956, was 53,914,355 and consisted of 21,769,699 subscribers and 32,144,756 dependents . . . an average of 2.48 members per subscriber contract. The national per cent of the population enrolled by Blue Cross Plans rose to 30.14. Enrollment in six states has exceeded 50 per cent of the state population—Rhode Island, Delaware, New York, Pennsylvania, Ohio, and District of Columbia.

Comparable Michigan Hospital Service figures as of

Thirst, too, seeks quality



December 31, 1956: Enrollment, 3,621,746 consisting of subscribers, 1,343,002 and 2,278,744 dependents . . . an average of 2.7 per subscriber contract. MHS at that date had enrolled 47.49 per cent of the state population. Michigan Medical Service for 1956: Enrollment, 3,613,263, consisting of subscribers, 316,066 and 2,297,197 dependents . . . an average of 2.7 per contract.

* * *

MEDICAL TELEVISION SHOWS

Produced by Michigan Health Council

WJBK-TV, Detroit

March 3—Subject: Attitudes and Alcoholism—Guests: Melvin Selzer, M.D., of Ypsilanti, and George Nimmo of Lansing.

March 10—Subject: Postgraduate Medical Education (M.C.I.)—Guests: Cecil W. Lepard, M.D., Detroit, and Otto O. Beck, M.D., Birmingham.

March 17—Subject: Vision—(Films—Eyes for Tomorrow and Light Is What You Make It).

March 24—Subject: Medical Technologists—Guest: Miss Dorothea Kanellos, Detroit. Also Film—Career Medical Technologist.

March 31—Subject: Orthodontics—Guests: Marvin Davis, D.D.S., and Bernard W. Lyon, D.D.S., both of Detroit.

WKAR, TV East Lansing

March 14—Subject: Operation Stop Polio—Guests: George A. Sherman, M.D., Fred S. Leeder, M.D., Jack C. Krause, and William Emery, all of Lansing.

March 28—Subject: Medical Technology—An Interesting Career—Guests: Marion Bennett, M.T., Sue Walters, M.T., and Margaret Smith, M.T., all of Lansing, and Athalie Lundberg, M.D., and Mary Baker, M.T., both of East Lansing.

* * *

Carbon Monoxide Danger—Automobile.—The University of Michigan and the City of Detroit are co-operating in a project which may point the finger of responsibility for many automobile accidents on an unavoidable by-product of our motorized age—carbon monoxide fumes.

The study is financed by a grant of \$44,000 from the U. S. Public Health Service.

Although there is no direct evidence so far that odorless carbon monoxide gases released in automobile exhaust have anything to do with the causation of accidents, it is known that certain physiological responses are affected by excessive inhalation of this gas, says Warren A. Cook of the U-M School of Public Health and Institute of Industrial Health, director of the study.

It is not necessarily the carbon monoxide itself which causes loss of visual sharpness, and increases drowsiness or headaches. These responses result from the chemical reaction which occurs when gas meets blood. Carbon monoxide has 200 times the affinity for combining with hemoglobin as does oxygen. This deprives the hemoglobin of its capacity for a normal oxygen content in the blood.

Field work for the investigation is being done on the streets of Detroit with the co-operation and assistance of the Detroit Health Department and its Bureau of Industrial Hygiene, the Detroit Police Department, the Department of Streets and Traffic, the Detroit Street

MAY, 1957

Say you saw it in the *Journal of the Michigan State Medical Society*

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Railway and the Detroit Edison Company. The School of Public Health administers the study.

Initial studies recording the amount of carbon monoxide in the air throughout the day and night have shown a lower number of parts per million of carbon monoxide in the air on the depressed express highways than on surface streets.

The U-M investigators are also interested in this study from its possible implications in various phases of occupational health. Although no information is available yet, scientists will be interested in professional drivers, truckers, cab drivers, delivery men, policemen, and others who are exposed to the possible harmful effects of carbon monoxide for as much as eight hours a day.

In order to keep the industry fully informed and to also have the advantage of its experience, a member of the Automobile Manufacturers Association has been invited to join the Project Advisory Committee. Target date for completion of the field work is fall, 1957.

The International Academy of Proctology announces the establishment of a Teaching and Research Fellowship in Proctology under the direction of Dr. Marcus D. Kogel, Dean of the Albert Einstein College of Medicine, New York. The Academy has voted a \$1,000 annual grant for each of three years to assist in the development of research and educational projects in proctology at the University.

The 1957 grant was accepted for the College by Dr. Abraham White, Associate Dean and Professor and Chairman of the Department of Biochemistry, at the

Ninth Annual Teaching Seminar of the International Academy of Proctology, April 29-May 2, 1957, at the Plaza, New York City.

One of the projects developed under this grant has been a tissue slide "library" for teaching purposes under the direction of Dr. Alfred Angrist, Professor of Pathology.

As emphasized by the founder and secretary of the International Academy of Proctology, Dr. Alfred J. Cantor, Flushing, New York, at the time of the Eighth Annual Teaching Seminar of the Academy in Chicago, the major function of the Academy is educational. All Academy funds are to be used for research and teaching projects in proctology so that earlier diagnosis and better treatment of patients with diseases of the colon and rectum may be made universally available.

* * *

Trans-Ocean Joint Meeting.—On Wednesday, June 5, the Harvey Tercentenary Congress will meet in London in the Great Hall of the Royal College of Surgeons to discuss "The Results of Cardiac Surgery." This meeting will commemorate the 300th anniversary of the death of William Harvey, the English physiologist who first described the circulation of the blood.

At the same time, the American Medical Association will meet in Carnegie Hall in New York City at 10:15 a.m. (EDT) where the Symposium on the Results of Cardiac Surgery will be carried to New York through the courtesy of Smith, Kline & French Laboratories. The two groups will be in direct communication with conversations carried by telephone and amplified in both places.

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WOMAN'S AUXILIARY TO THE AMERICAN MEDICAL ASSOCIATION

Thirty-fourth Annual Meeting

New York State is honored by serving as host to the American Medical Association and its Woman's Auxiliary, the latter, the parent body of all State and County Auxiliaries.

Mrs. Harry F. Pohlmann of Middletown, New York, a past President of the Woman's Auxiliary to the Medical Society of the State of New York and past chairman of several committees of the AMA Auxiliary, has been named Convention Chairman for this meeting by the national President, Mrs. Robert Flanders, of Manchester, New Hampshire.

Headquarters for the Auxiliary's meeting will be the Hotel Roosevelt at Madison Avenue and 45th Street, New York, from June 3 to 7, 1957. The Roosevelt is within walking distance of the Waldorf-Astoria Hotel, where the AMA House of Delegates meet, and proximity to Fifth Avenue and Madison Avenue shops, theatres and innumerable points of interest, make the location of headquarters ideal.

Registration will open on Sunday, June 2, at 11:30 a.m. and will continue through Thursday. On Monday, June 3, and Wednesday afternoon, June 5, there will be round table discussions of interest and educational value to all physicians' wives. Members and guests are cordially invited. The general meeting will be held Tuesday, Wednesday, and Thursday until noon, and a Board

of Directors' meeting at one o'clock on Thursday. A post-convention Workshop for State Presidents, Presidents-Elect and National Committee Chairmen will convene Friday, June 7.

Social activities include:

Monday, June 3—Tea, honoring President and President-Elect.

Tuesday, June 4—Luncheon in honor of the National Past Presidents, at which Dr. Howard Rusk, Director of the Institute of Physical Medicine and Rehabilitation of the New York University Bellevue Medical Center, will be the guest speaker. Dr. Rusk needs no introduction—he is internationally known and is a fine speaker.

Wednesday, June 5—Luncheon in honor of the National President and President-Elect. Dr. Dwight H. Murray, President of the American Medical Association, will be the guest speaker.

Thursday, June 6—Annual Dinner for Auxiliary members, husbands and guests, at which the guest speaker will be Professor Allen Richard Foley of Dartmouth College.

It is hoped that each State and County Auxiliary and the territorial Auxiliaries will be well represented. A warm welcome awaits everyone, and a profitable meeting and many hours of pleasure will make your visit a memorable one.

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Convention Publicity Chairman

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MEDICAL RESIDENT STAFF

FOR information write to

Louis L. Amato, M.D., Medical Director

Kenneth A. Dahl, Administrator



SIXTY-FOURTH ANNUAL MEETING OF THE UPPER PENINSULA MEDICAL SOCIETY

Houghton, Michigan, June 21-22, 1957

Thursday, June 20

A.M.

9:00 Executive Committee of The Council of MSMS will meet all day at the Miscowaubik Club, in Calumet. Dr. and Mrs. T. P. Wickliffe will be hosts. All MSMS members are invited to the session to see how The Council functions.

P.M.

6:00 Cocktails and buffet supper for the exhibitors at the Onigaming Yatch Club in Houghton. Houghton-Baraga-Keweenaw Society will be host. All visitors are invited on a "Dutch-Treat" basis.

Friday, June 21

A.M.

9:00 Registration and View Exhibits—MCMT Union Ballroom.

9:45 Welcome—T. P. Wickliffe, President, Upper Peninsula Medical Society.

All Scientific Meetings at the Union.

Moderator—SIMON LEVIN, M.D.

10:00 R. J. ROGERS, M.D....."Application of Smear Technique in the Diagnosis of Cancer"

10:30 ARNOLD JACKSON, M.D....."Regional Enteritis"

11:00 FRANCIS MURPHY, M.D....."Diagnosis and Treatment of Acute Coronary Conditions"

11:30 MOSES COOPERSTOCK, M.D....."Present-Day Trends in Infant Feeding"

M.

12:00 Luncheon at Union (Tickets to be purchased at Registration)

Moderator—A. M. ROCHE, M.D.

P.M.

2:00 JOSEPH GALE, M.D....."Mediastinal Tumors"

2:30 HARRISON McLAUGHLIN, M.D....."General Principles in the Management of Fractures"

3:00 CARL MOYER, M.D....."Present Ideas of Treatment of Varicose Veins and Ulcers"

3:30 Recess to View Exhibits

Moderator—PERCY MURPHY, M.D.

4:00 HAROLD FALLS, M.D....."Constitutional Disease"

4:30 G. J. CURRY, M.D....."The Fractured Wrist"

5:00 A. C. CURTIS, M.D....."Some Recent Studies on the Abnormalities of Pigmentation"

5:30 L. F. FOSTER, M.D., Secretary MSMS
TOM PATON, Michigan Medical Service Representative

6:30 Cocktails and Dinner—Douglass House, Houghton. (Tickets to be purchased at Registration)

8:30 Introduction—T. P. WICKLIFFE, M.D., President
Upper Peninsula Medical Society

Public Address at Auditorium, Houghton High School

ARCH WALLS, M.D., President, MSMS

Saturday, June 22

Moderator—ALFRED LABINE, M.D.

A.M.

9:00 R. O. BERGAN, M.D....."Antibiotic Therapy in Pediatrics, Recent Developments"

9:30 HARRISON McLAUGHLIN, M.D., RAHN, M.D.,
LYTTLE, M.D., G. J. CURRY, M.D.....Panel on
"Trauma"

10:30 View Exhibits

11:00 HAROLD WALDER, M.D....."Antibiotics in Urinary Tract Infections"

11:30 MEYER DAVIES, M.D.....(to be announced)

M.

12:00 End of Scientific Meeting

P.M.

6:00 Cocktails, Michigan Medical Service, Host.
Cocktails, Dinner and Dance at Onigaming Yacht Club. (Tickets to be purchased at Registration.)

BLUE SHIELD LEAVES LOW-VAULTED PAST

(Continued from Page 572)

\$25 for a consultation, \$15 per hour or fraction thereof for "prolonged detention with patient in critical condition," and also such increased surgical fees as \$500 for the excision of an intervertebral disk with spinal fusion, for cardiorrhaphy or for total gastrectomy instead of the current \$300. Furthermore, the Blue Shield Fee Committee is presently working on the difficult problems of preparing a table of relative values for various procedures. Once this is done, it will be possible to consider a simultaneous percentage increase in fees "across the board" to correspond with increasing income levels, whenever such an increase is needed.—Editorial, *New England Journal of Medicine*, Feb. 28, 1957.

Correspondence

Dear Dr. Haughey:

I was very much amazed at the very wide circulation of *THE JOURNAL*. Requests for reprints of "Arabian Medicine in the Post-Koranic Period" came from all over the country and even from Europe and the Middle East.

With warm personal regards, I am,

Sincerely yours,

BENJAMIN L. GORDON

Ventnor, New Jersey

March 5, 1957

* * *

Dear Doctor Haughey:

I hope sometime soon you will see fit to editorialize this society in transition and what effort the physiatrist is trying to exert to prevent our public health group, non-official more than official, from dislocating the private practice of medicine in this fantastically hysterical endorsement of rehabilitation centers.

The word itself has so much semantic magic that entire communities, including members of our own profession, are seduced without ever applying objective reasoning before whole-hearted endorsement.

Even the Father of Rehabilitation himself, H. A. Rusk, M.D., has repudiated the idea of the Rehabilitation Institute and now has wholeheartedly entered into the chronic illness field guided by the sound grasp of the situation held by Dean W. Roberts, M.D., M.P.H.: "The Overall Picture of Long Term Illness." (*Journal of Chronic Diseases*, Vol. 1, Pages 149-159, Feb. 1955.)

Official, quasi-official and non-official public health people have continued, by inertia and perhaps pride, in the original direction proposed by Dr. Rusk. You will find all over this state, from Detroit to Battle Creek, a few busy beavers coming into a community, selling the community a real bill of goods; namely, this—"Now your community needs a few extra dollars. We have it. You have a curative workshop. Let us, with your facilities and our money, team up and get a Rehabilitation Center going." This sounds good (to everybody). Meantime, before even the Community Council, which has the overall planning of the community's needs in mind, has been informed, a Board is set up and incorporated as a non-profit agency. Generally, such a board consists of the most prominent and influential citizens of the community and they do have the interest of the community at heart—this is the sad thing. A few expedient individuals can sew up an entire community in its desire to do good—and we then have Rehabilitation Center ad infinitum with very often a doctor fronting for this non-profit corporation, as an administrator.

Dr. Haughey, I do not want social workers, vocational counsellors, and the Federal Government dictating for me or for any other physician, my relationship to my patient. Yet this is the thing we ask as physicians, every time we invite (having also been seduced) a rehabilitation center into our home community.

Sincerely,

K. McMORROW, M.D.

Detroit, Michigan

March 11, 1957

MAY, 1957

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THE DOCTOR'S LIBRARY

Acknowledgment of all books received will be made in this column, and this will be deemed by us as full compensation to those sending them. A selection will be made for review, as expedient.

BOOKS RECEIVED

HOME HEALTH EMERGENCIES. A Guide to Home Nursing and First Aid in Family Health Emergencies. Part One, Home Nursing; Part Two, First Aid. New York: Medical Department, The Equitable Life Assurance Society of the United States.

LITERATURE REVIEW. CIBA. Produced by the Medical Information Service For Internal Circulation. Vol. 1, No. 12 (Dec.) 1956. Basle, 1956.

THE ROCKEFELLER FOUNDATION ANNUAL REPORT, 1955. New York, 1956.

CLINICAL ORTHOPAEDICS. Anthony F. DePalma, Editor-in-Chief, with the assistance of the Associate Editors, the Board of Advisory Editors, The Board of Corresponding Editors. Number Seven. Philadelphia and Montreal: J. B. Lippincott Company. Price \$7.50.

TUBERCULOSIS IN OBSTETRICS AND GYNECOLOGY. By George Schaefer, M.D., F.A.C.S., F.I.C.S., Assistant Professor of Clinical Obstetrics and Gynecology, Cornell University Medical College; Attending Obstetrician and Gynecologist, Triboro Hospital; Diplomate American Board of Obstetrics and Gynecology; Fellow American Academy of Obstetrics and Gynecology; Fellow American Trudeau Society. With 58 halftone illustrations. Boston-Toronto: Little, Brown and Company, 1957. Price \$8.75.

THE YEARBOOK OF MODERN NURSING, 1956. A Source Book of Nursing. Editor, M. Cordelia Cowan, Nursing Educator, Author, Editor. Foreword by Mary M. Roberts, Editor Emeritus, American Journal of Nursing. New York: G. P. Putnam's Sons, 1957.

A PSYCHIATRIC GLOSSARY. The Meaning of Words Most Frequently Used in Psychiatry. By the Committee on Public Information, American Psychiatric Association. New York: American Psychiatric Association, 1957.

COMPETITIVE PRESSURE AND DEMOCRATIC CONSENT. By Morris Janowitz and Dwaine Marvick. University of Michigan, Michigan Governmental Studies, No. 32. An Interpretation of the 1952 Presi-

dential Election. Morris Janowitz is Associate Professor of Sociology and Research Associate, Institute of Public Administration, University of Michigan, and Dwaine Marvick is Assistant Professor of Political Science, University of California (Los Angeles). Ann Arbor: Bureau of Government, Institute of Public Administration, University of Michigan, 1956. Price \$2.75.

CLINICAL ORTHOPAEDICS. Anthony F. DePalma, Editor-in-Chief, with the assistance of the Associate Editors, The Board of Advisory Editors, The Board of Corresponding Editors. Number Eight. Fall, 1956. Philadelphia and Montreal: J. B. Lippincott Company, 1956. Price \$7.50.

Volume 8, like its predecessors, continues the symposium form of presentation, which this time deals with chronic hereditary diseases and developmental anomalies. In addition, there is a special section dealing with motorist injuries and motorist safety.

The current volume continues to be quite readable, both in the manner of material presentation and typographical layout. As a single unit, this book is of primary interest to the orthopedist and not to the casual passer-by, however, the series as a whole would be a valuable addition to any physician's library.

The lead section, dealing with chronic hereditary diseases and developmental anomalies, does not attempt to cover the field in the space available, but does concentrate primarily on defects and diseases of the skeleton with a particularly excellent review of the genetics of joint diseases.

The second section, concerning general orthopaedics, presents a discussion of several orthopedic diseases, not particularly related to one another or to the lead section, and has a discussion of problems related to the use of prostheses in children, which is a wonderful review of the etiologic and psychobiologic factors involved. This particular article does not deal with the technical factors involved, but with all the "patient-as-a-whole" factors with which any physician might find himself involved.

The third section, dealing with motorist injuries and motorist safety, is often technical, but from an engineering view would be of great interest to the motoring buff. The historical development of auto crash injury research is presented too, along with a good paper on the engineering aspects of fractures.

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GENERAL UROLOGY. By Donald R. Smith, M.D., Clinical Professor of Urology and Chairman of the Department of Urology, University of California School of Medicine, San Francisco; Consulting Urologist, San Francisco Hospital, and Consulting Surgeon (Urology), Veteran's Hospital, San Francisco; Chief of the Department of Urology, St. Luke's Hospital, San Francisco. Illustrated by Ralph Sweet. Los Altos, California: Lange Medical Publications, 1957. Price \$4.50.

Doctor Smith has treated the subjects in his book in a very comprehensive simplified manner which really conveys to the reader the essence of the topic without a lot of surplus reading. It is an excellent reference work for the busy urologist who desires the synopsis of a subject written in an easily understood capsule form. I am sure there is a ready need for a book such as this, and I feel it is a most outstanding book of its kind.

W. R. C.

CARCINOMA OF THE BREAST: The Study and Treatment of the Patient. By Andrew G. Jessiman, F.R.C.S., M.D., Henry E. Warren, Fellow and Assistant in Surgery, Harvard Medical School; Junior Associate in Surgery and Cancer Co-ordinator, Peter Bent Brigham Hospital, and Francis D. Moore, M.D., Moseley Professor of Surgery, Harvard Medical School; Surgeon in Chief, Peter Bent Brigham Hospital. 115 pages. Illus. Boston and Toronto: Little, Brown and Company, 1956.

This book is part of the *New England Journal of Medicine* Medical Progress Series, and is an expansion of three very fine articles on this topic which appeared in that journal. Charts, pictures of gross and microscopic specimens of carcinoma of the breast and many illustrations have been added which did not appear in the original articles.

Many of the controversial aspects of the treatment of this field of cancer are presented fully by the authors who present their own conclusions after thorough discussion, giving the readers the fruits of their experience based on the premise: "In the light of the present evidence, what is best for the patient?" The current "McWhirter controversy" with its local treatment is presented; when to use irradiation; androgen or estrogen therapy; cortisone; when to use castration (x-ray versus oophorectomy); adrenalectomy; hypophysectomy are all thoughtfully discussed.

Particularly good treatment is given the various stages of the disease in Chapter VIII as the authors divide breast cancer patients into eight different clinical types and present a suggested outline of treatment for each type (the "young and early,"—"the old and early"—"slow, no bones" etc. This particular classification is carried out with a completeness rarely found in other monographs. The summary suggests: "Accurate surgery, accurate endocrinology and accurate radiology are equally essential in achieving the curative or palliative results made available to the patient by recent advances in clinical science."

This is an excellent reference for the surgeon in particular, and would interest every physician whose patients fall in this field.

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*Ferguson, J. T., and Linn, F. V. Z.: Antibiotic Med. & Clin. Therapy 3:329, 1956.



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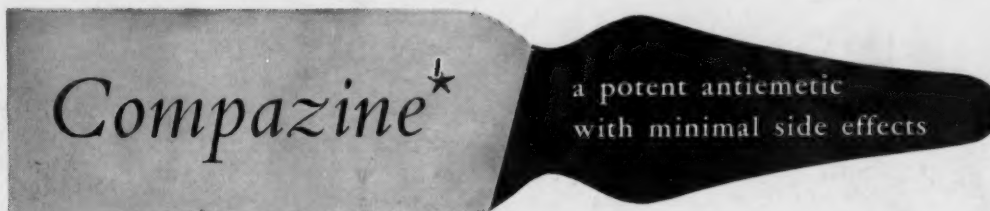
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